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Chapter 5

Balancing Operational Services in Healthcare: An Indonesian Perspective

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Additional information is available at the end of the chapter

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Abstract

The purpose of this chapter is to discuss the concept and application of business management services, especially healthcare services. This chapter also features an important issue in healthcare management, balancing conceptual and applied operational services and marketing in healthcare management. The text is organized in four parts. The emphasis is essential uniqueness of healthcare service management. The first part contains an introduction to healthcare covering a wide range of healthcare settings, such as clinics, hospitals, beauty treatments, fitness centers and so on. The second part contains the design of the quality of primary and secondary level healthcare services, measurement, strategies and impacts. The third part contains a healthcare customer satisfaction guarantee, experience, expectations and performance, including dissatisfaction, switching healthcare provider, trust, commitment and patient loyalty. The fourth part contains changes in healthcare business, government policies, information technology, access to health care, and state and private health insurances in Indonesia.

Keywords: operation services, service management, healthcare management, Indonesia

1. Introduction

Operation management is the activity of managing the resources which are devoted to the production and delivery of products and services or in other words about how organizations produce goods and services. Every organization has an operation function because every organization produces some type of products and/or services [1]. Roth and Larry [2] define the concept of service operationally as the core portfolio and the device service element. There are five elements of the core services, namely:

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1. supporting facilities, such as physical and structural sources that must be in place for services to be delivered,
2. the facilitating goods that comprise the materials, supplies and merchandise that are used or consumed in the service delivery process,
3. the facilitating information that supports or enhances the execution of the explicit services,
4. the explicit services that represent the customer's experiential or sensual benefits; and
5. the implicit services, which are characterized by psychological benefits or more.

The customer always has to interact with the service provider, while producing the services, in the service company. Contact may also be indirect, the service process continues for a long period of time, resulting in a large number of contacts and interactions, in a certain way. This interaction can take a long time. If the customer feels that they are getting a lower quality, the exchange value of money stops and why should they stay? [3]. Satisfaction with a core service is important for overall customer satisfaction and, in turn, for customer loyalty [4]. This also applies to healthcare services, such as clinics, hospital, beauty care, fitness center and so on.

Consumers in healthcare are patients. They have less choice of type and quality of treatment provided—both personal and therapeutic—unless the patient is a medical/paramedical officer. He has no choice in terms of diagnosis, various tests, and scans to do. There is also no choice about prescribed medications. Salgaonkar describes that such a patient is in the hands and control of the doctor, like a child in hands of the mother [4]. Healthcare is a unique field and therefore cannot be held to the same customer service standards of other industries [5].

2. Healthcare services

2.1. Measuring the quality of health services

Use of a widely accepted quality assurance tool in healthcare and social services is an essential procedure of effective and result-oriented quality management [6]. Service quality (servqual) measurement techniques are increasingly being studied and have been a key area in the marketing literature over the last few decades, including quality dimensions [7]. A multiple-item scale of servqual developed by Parasuraman, Zeithaml and Berry in a series of studies of six service firms (1985 [8], 1988 [9], 1991 [10], 1994 [11]) by refining and replicating in some samples shows that the difference between consumer expectations about the performance of service firms and actual performance provides a consumer perception of service quality. Servqual is also developed by Cronin and Taylor. The authors investigate the conceptualization and measurement service quality and relationships between service quality, consumer satisfaction and purchase intentions [12]. Cronin and Taylor also measured service quality by reducing expectations in the perceptual model [13].

Nowadays, Internet, in addition to facilitating human interaction, also has become an important channel for service delivery; however, many aspects of both the content and the process

of how to measure online service quality are still much discussed by many scientists. Rolland and Freeman have designed, developed and evaluated a reliable and valid scale for the measurement of electronic service quality, specifically in the retail business in French context. The authors have extracted the dimensions matched five of the nine factors identified in the literature review, namely: ease of use, information content, security/privacy, fulfillment reliability and post-purchase customer service [14]. Piercy uses 3399 samples from 4 companies (2 pure plays and 2 multi-channels) to develop 9 dimensional online service quality models, namely: the website, trust, customer service, information, ease of contact, no advertisements, personalization, company image and product range. The author found the trust in the company and the online pure-play companies to be the most important dimensions of online service quality, with customer service also highly rated [15].

According to Baird, healthcare is a highly personal service. Patients are usually under emotional and physical stress. If all healthcare employees can act with compassion and care as they come into contact with patients, visitors and other family members, they will feel safe for receiving needed services for disease treatments, diagnosis and prevention [16]. Lee measures service quality in healthcare organization with namely HEALTHQUAL. HEALTHQUAL is an integrated model to measure the health care satisfaction questionnaire (HCSQ) based on the patient's view, the hospital view and the perspective of accreditation institutions.

HEALTHQUAL is divided into two aspects: process and result. Process is divided into four aspects, namely, empathy, tangible, safety and efficiency. While the result consists of degree of improvements of care service [17], the determinants of hospital service quality according to Zaim et al. were broken down into two main categories, namely tangible factors, which refer to technology, physical facilities, personnel, communication materials and so on, and the intangible factors, consisting of five sub-factors, namely reliability, responsiveness, assurance, courtesy and empathy [18].

2.2. Strategies and impacts

Service providers must be able to provide the services of quality in accordance with the expected customers, because the role of service quality is still recognized as an important factor in the survival of a service company. Each time a customer comes in contact with every aspect of the service system (service meeting), they are presented with an opportunity to evaluate the service provider and form an opinion of service quality. In healthcare, the patient is the consumer, who is a customer of healthcare, and is a different kind of customer from other customer types of services. It may be that other consumers may postpone the decision to use the service, but the patient has to take action immediately. The patient's behavior is determined by various unavoidable factors such as the patient's physical condition, the illness involved, the seriousness of the case and so on. [4].

According to Kotler, satisfaction is a function of performance and perceived expectations. It forms three impacts: that if performance equals expectations of customers, it will cause satisfaction, if performance is less than expectations of customers, it will cause dissatisfaction and if performance exceeds the expectations of customers, it will cause increased satisfaction and

happiness [19]. While Baker said that there are differences in managing expectations between patient's expectations and actual experience [20]. Patients who are vulnerable and often ill, physically and/or emotionally, have great expectations in each visit. Each patient has a set of variables that affect their level of satisfaction, involvement and, ultimately, loyalty [16].

3. A healthcare customer satisfaction guarantee

3.1. Experience, expectations and performance

When a patient arrives to get in touch with a healthcare provider until completion, the patient assesses his experience. The patient's direct experience of the treatment process through a clinical meeting or as an observer (e.g., as a patient on a hospital ward) can provide valuable insights both physically and non-physically through vision [21].

Parasuraman, Berry and Zeithaml conducted a study of customer expectation. Their findings indicate that customer service expectations have two levels: desired and adequate. The desired level of service is the service that customers expect to receive. The adequate level of service is the service that the customers find acceptable. Customers believe the desired service as a "can be" and "should be" service, adequate service as a "will be" service, both separated by a zone of tolerance. The researchers also explained that the three levels tend to be different for the reliability result dimension and the tangible, responsive, assurance and empathy process dimensions. According to them, the consumers view reliability as the core of service and tend to have higher expectations for it [22].

Patient's expectations of the process and outcome of treatment develop from three main sources [23]:

1. previous experiences and memories in the specific and related settings;
2. comes from word of mouth, experiences shared by family members and friends and media and advertising, including both television and print media;
3. develop through a number of different processes which may depend on the nature of the expectations.

3.2. Patient satisfaction, dissatisfaction and switching healthcare provider

As Kotler explains earlier, satisfaction occurs because consumer expectations are in line with performance. Customer satisfaction and patient satisfaction cannot be equal, because health is typically a complex blend of emotions, the real and the unreal, and the consumption of health cannot be seen [24]. Patients do not readily express their feelings regarding the quality of healthcare they received [4]. A patient said that they are satisfied sometimes using assumptions that patient satisfaction can be useful as an indicator of health [25]. When patients are disappointed with the care they receive, they switch healthcare providers [26, 27].

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3.3. Trust and commitment

According to Berry, companies can build consumer trust in three ways [28]:

1. open lines of communication,
2. guarantee their services, and
3. provide higher standards of behavior.

Everything a patient sees, hears, feels and experiences in a healthcare setting should instill trust [16]. Morgan and Hunt propose a model in which commitment and trust are the keys to the success of a marketing relationship, with the impact [29]:

1. encouraging exchange partners to preserve investment in relationships,
2. hindering the search for short-term alternatives, and
3. keeping the belief that the couple will not act opportunistically.

Morgan and Hunt also say that trust is the key to commitment in relationship marketing. However, the relationship between patients with service providers can affect patient satisfaction in primary and secondary healthcare [30].

3.4. Patient loyalty

Brand loyalty and customer loyalty have almost the same meaning. Dick and Basu designed the concept of customer loyalty as the relationship between a person's attitude toward an entity (one of which is service) and one's patronage behavior [31]. Meanwhile, Gremler and Brown say that there are three separate dimensions of customer loyalty: behavioral loyalty, attitudinal loyalty and cognitive loyalty [32].

Astuti and Nagase explain patient loyalty into three groups, namely reinforcement of loyalty, weakened loyalty and potential destruction of loyalty [27]. Relationship marketing, patient satisfaction and retention programs are variables to build reinforced loyalty. Based on their hypothesis that loyalty will increase when there is an interactive relationship that adds value to patients with healthcare providers, appreciation, happiness and happiness reactions to treatment services that meet expectations and retention programs are designed to encourage patients to return. However, some variables have different effects to patient loyalty on hospital than clinical. For instance, the retention program did not meet the criteria for status as a predictor of loyalty to the hospital.

Loyalty will be reduced when the patient decides to try treatment elsewhere, experience dissatisfaction or receive negative information about service performance. The analysis results show that switching service providers has a significant negative impact on loyalty for the clinic but is not the case for hospitals although the direction of the relationship is negative. In other words, hospitals can benefit from spurious loyal customers. Based on Bloemer and

Kasper, spurious brand loyalty, the repeat buying of the brand, is not based on any real commitment but on inertia [33].

The variable that has the potential for destruction of loyalty is relationship marketing, which has a significant negative effect on the switching provider. Hospitals and clinics provide services through good relationships between patients and providers. If the service provider does not build a good relationship, the patient moves, the relationship ends and potential loyalty is destroyed, which will ultimately increase the patient's desire to change healthcare providers.

4. Health business in Indonesia

4.1. Changes of healthcare business in government policies

Based on the results of the Organizational for Economic Co-operation and Development (OECD) survey, Indonesians believe that the government's actions and policies should work to realizing the progress and prosperity of the people, including health issues. Excitingly, Indonesia is ranked first where the level of public confidence to the government is in the top position. Based on these data, 80% of people believe in the government's move [34].

The government has changed various arrangements on healthcare business, such as the organization of clinics. Clinics as providers of health services at the beginning of the community should be appropriate in development and protection to the community, the land of establishment and adequate facilities and infrastructure. Even clinics can open inpatient services [35]. In order to improve the quality and range of advanced services, the Government of the Republic of Indonesia regulates the hospital. This is to regulate the rights and obligations of the community in obtaining health services. The rules are regulated in the Act, that the hospital is a health service institution that organizes health services, individuals who provide inpatient, outpatient and emergency care services [36]. To improve accessibility, affordability, patient and community protection and the quality of pharmaceutical services, it is necessary to arrange pharmaceutical services in pharmacies. This pharmacy is also regulated in the Regulation of the Minister of Health of the Republic of Indonesia Number 9 Year 2017 [37].

4.2. Access to health services and information systems

The development of health services has succeeded in improving the health status of Indonesian society, although not yet felt even in remote or isolated areas, including coastal areas and small islands. The government therefore undertakes the fundamental efforts of improving access to health services to these areas. People in urban or rural areas can easily get access to the health services they want, both government and private health services.

Limitations or unavailability of data and information accurate, precise, and fast are the factors that hinder people from accessing health services. Therefore, the government also made reform through Act Number 36 Year 2009, which stated that to organize effective and efficient health efforts, health information is required health information [38].

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4.3. State and private health insurances

Health insurance in Indonesia is experiencing significant growth. History records that health insurance began in 1960. Over time, the government improved the insurance system in Indonesia. In 1992, the government mandated the Public Health Maintenance Guarantee Program, and then in 1996 the government developed the Social Safety Net program. In 2003, the government implemented Poor Family Health Care Security in 3 provinces and 13 districts [39]. In 2005, a health insurance program was introduced for the poor (under the name of Askeskin), a subsidized social health insurance intended for the informal sector and the poor [40]. Askeskin has been shown to lower out-of-pocket spending by 34% of the poor [41]. Then on January 1, 2014, the government incorporated several insurance companies to serve the National Health Insurance, which established the Social Security Administering Body [39]. This institution is a public legal entity which is directly responsible to the president and has the duty to organize national health assurance for all Indonesian people, especially for civil servants, civil servant pensioners and army/police, veterans, pioneers of independence and their families and business entities and others or ordinary people. Article 14 states that every Indonesian citizen and a foreigner who has worked in Indonesia for at least 6 months shall be a member of the Social Security Administering Body. In addition, each company must register its employees as a member of this health insurance institution. The person or family who is not working at the company must register themselves and their family members at this institution. Each participant of this institution will be drawn of a fee whose amount is determined later. For the citizens unable to pay, the contribution is borne by the government through an aid program for the poor [42].

The government has obliged the public to use insurance under government-appointed institutions; is private insurance still needed? The Social Security Administering Body Health becomes the standard protection received by the community that has become a participant. However, due to its standard service, not all match this health insurance service. There are services that may not be covered, or a standard service, so that people who need more personalized or more convenient services also add private commercial insurance. Insurance in Indonesia is governed by the government; it is intended to provide assurance to both insurer and insured parties in order to be responsible for all their respective obligations.

5. Future research

The potential for the development of healthcare business in Indonesia is still very good. It is proven many clinics, private hospitals, provide a satisfactory service. Clinic provides a variety of services, such as beauty treatments. So does the hospital, providing a variety of services for certain diseases.

Unfortunately the completeness of the service for treatment is only available in big cities. But different for remote areas, even patients have to travel that is not easy, as must through the

river, forest or barren areas. Medics or paramedics are also still few who serve such a society. Therefore, it is better for the government to build a place for treatment in an area that is easily accessible by the patient. The government should also offer research projects for researchers aimed at solving access problems. Or it can be done by independent researchers to overcome the problem of accessing difficulties by creating a community that understands health problems especially for elderly patients. So in case of emergency the community can cope faster before being taken to the nearest clinic or hospital.

6. Conclusions

The concept and application of business management services, especially health services, is part of a more specific operational management. Balancing concepts and practices are discussed in the area of marketing management, particularly service issues. Basic and advanced healthcare services may differ in service from ownership, such as government and private property, or from financing for medical treatment, such as government financing through national insurance or self-financed through insurance.

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