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Different Perspectives on Health Care Quality: Is the Consensus Possible?

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For the success of health care organizations, accurate measurement of health care service quality is as important as understanding the nature of the service delivery system. Without a valid measure, it would be difficult to establish and implement appropriate tactics or strategies for service quality management.

Experts have struggled for decades to formulate a concise, meaningful and generally applicable definition of the quality of health care. However, the complexity and variability of many definitions are very confusing even to experts. Patients, service providers and other parties involved in the process of health care service delivery, understand and describe service quality in different ways. Different perspectives on health care quality lead to different expectations and different methods of quality measurement.

Patients tend to evaluate health care quality according to the responsiveness to their specific needs. Medicine has made remarkable advances over the past century and patients expect to get modern medical help, which would solve their health problems; medications that can cure a number of physical and psychological problems; surgery that can undo the inborn deficiencies and damage caused by accidents or diseases that until recently meant death or disability. Most patients define quality as efforts of physicians to do everything possible for a patient. Patients' expectations about the health care system may differ from those of health care professionals and managers. For example, shorter visit lengths, which reduce the cost of providing ambulatory care, may have a negative effect on patients' ability to participate in making choices about their care. On the other hand, patients cannot evaluate many technical aspects of health care quality. Physicians can provide a high level technical quality but still be rated low by patients because of the lack of humanity, responsiveness or satisfaction.

For physicians and other health care providers measurement of quality has typically been driven by medical outcomes. However, outcomes indicative of quality may differ for a patient and physician. For example, although an oncologist may consider radiographically documented shrinkage of tumor size a desirable outcome, the patient may not care about tumor size and may rather consider improvement in health-related quality of life as the most desirable outcome.

Health care administrators often use managerial input measures such as the average number of nursing hours required for an outpatient surgery.

Considering all above mentioned, this article aims to reveal the similarities and differences between three competing perspectives on health care quality and to provide a way of integrating perceptions and needs of every group involved into one coherent approach to health care quality and its measurement.

Keywords: *health care quality, patient perception, physician perception, managerial perception of quality.*

Introduction

Quality measurement and management is one of the most important topics in all services, including health care, nowadays. There are many structured and unstructured efforts to measure various components of quality. However, health care system still lacks a unified process for assessing the various elements of quality. It is not surprising knowing the complexity of health care services and difficulty of service quality evaluation.

According to McGlynn (1997), patients, service providers and other parties involved in the health care system, define quality differently what leads to the use of different methods of quality evaluation. The most commonly accepted definition of health care quality was proposed by Institute of Medicine (IOM) in 1990, where quality of care was defined as *"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"* (IOM, 1999). This definition discloses well the complexity of the concept of quality and quality evaluation. In designing a coordinated strategy, one must ensure that the complex dynamics of health care delivery, the varying levels at which care might be evaluated, and the different perspectives of the key stakeholders in the system are adequately represented.

To some extent quality is "in the eye of the beholder". That is the reason why expectations associated with different aspects of care are likely to vary among different stakeholders. Considering this, ***the problem of this paper*** can be formulated as the following question: is the consensus among different perspectives on health care quality possible?

The aim of this paper: To analyze different perspectives on health care quality in the level of health care organization and to determine quality dimensions, important to patients, health care professionals and managers, so that quality evaluation would encompass all important aspects.

Research object: the views on health care quality from different stakeholders in the health care organization.

Research methods: systemic and comparative analysis of scientific literature.

We will begin with a conceptual overview of definitions of health care quality; distinguish between three major perspectives on health care quality at the level of health care institution, from the patient, professional and manager point of view. Next, we will discuss the possible way of integrating all these different perceptions.

Concept of healthcare quality

Many efforts have been made trying to develop the thorough and generally applicable definition of health care service quality. Donabedian (1980) defined health care service quality as *"that kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts".* In 1984 the American Medical Association defined health care service quality as such care, *"which consistently contributes to the improvement or maintenance of quality and/or duration of life"* (Blumenthal, 1996). The association identified specific attributes of care that should be examined in determining its quality, including an emphasis on health promotion and disease prevention, timeliness, the informed participation of patients, attention to the specific basis of medicine, and the efficient use of resources. Quality has also been defined as *"the abilities to reach the desired objectives using legitimate means"*, where the desired objectives implied *"the achievable level of health"* (Donabedian, 1988). Thus, quality is attained when a physician properly helps the patient to reach an achievable level of health. According to Helminen (2000), this definition emphasizes the professional point of view. The European Committee for standardization in 1994 suggested more generalized definition of quality: *"Quality is the totality of characteristics of an entity that bear on its ability to satisfy stated or implied needs"* (Helminen, 2000). Such a definition allows integrating both service providers' and patients' expectations, when talking about health care service quality. On the other hand, Ovretveit (1992) defines quality as *"fully meeting the needs of those who need the service most, at the lowest cost to the organization, within limits and directives set by higher authorities and purchasers".*

These different approaches to quality show that there are several different perspectives to quality of health care, at which quality can be analyzed. Different perspectives on and definitions of quality logically call for different methods of quality measurement and management.

Patients perceived health care quality

Patients tend to define quality in terms of their preferences and values, and that leads to quality definition emphasizing satisfaction with health care and the results, such as recovery, mortality and functional status.

An interest in the views of patients is not fundamentally inconsistent with physicians' views of quality. When talking about the quality of personal interaction between the service provider and the client, health care professionals have always acknowledged that satisfying patients is essential to providing high quality care. However, at the same time, physicians have often discounted the importance of patients' perspective stating that patients have very limited knowledge of what constitutes technical quality and because of the difficulty of measuring patients' views accurately and reliably.

Both political and scientific developments have fostered the growing emphasis on the importance and legitimacy of patients' perspectives on the quality of care. Using psychometric techniques, researchers have developed better measures of patients' evaluations of the results of care, thus allowing patients' views to be assessed with greater scientific accuracy. The view that consumers should have information and other resources necessary to make judgments about the value of goods and services finally was bound to influence and health care sector. The concept of "patient-centered care" emerged (Blumenthal, 1996).

Patients tend to evaluate health care quality according to the responsiveness to their specific needs. Most patients define quality as efforts of physicians to do everything possible for a patient. They often focus on effectiveness, accessibility, interpersonal relations, continuity and tangibles as the most important dimensions of quality. However, it is important to note that patients do not always fully understand their health service needs and cannot adequately assess technical competence. Health providers must learn about their community's health status and health service needs, educate the community about basic health services, and involve it in defining how care is to be most effectively delivered (Brown et al., 1992).

The most widely known and discussed scale for measuring service quality from the service recipient point of view is SERVQUAL (Parasuraman, Zeithaml, Berry, 1985; 1988). After a subsequent testing, authors identified 5 service quality dimensions: *1) reliability, 2) assurance, 3) tangibles, 4) responsiveness* and *5) empathy.* SERVQUAL has been also applied to the health care field in numerous researches (Babakus and Mangold, 1992; Brown and Swartz, 1989; Carman, 1990; Walbridge and Delene, 1993; Bowers et al., 1994; Lim and Tang, 2000; Lee et al., 2000; Koerner, 2000; Tucker and Adams, 2001; etc.). However, many researchers found, that SERVQUAL do not encompass all the dimensions of professional service quality and additional dimensions should be added, representing more technical quality aspects (for example, "core medical service" – Haywood-Farmer and Stuart, 1988, Lee et al., 2000; etc.), which are very important in health care.

Health care professional's attitude to health care quality

Health care professionals (physicians) tend to define quality in terms of the attributes and results of care, and this definition emphasizes the technical excellence with which care is provided and the characteristics of interactions between provider and patient.

According to Blumenthal (1996), technical quality of health care has two dimensions: 1) the appropriateness of the services provided and 2) the skills with which appropriate care is performed. High technical quality

consists of "doing the right thing right". To do the right thing requires that physicians make the right decisions about care for each patient (high quality decision making), and to do it right requires skills, judgment and timeliness of execution (high quality performance). The quality of the interaction between physician and patient depends on several elements in their relationship: quality of communication, physician's ability to maintain the patient's trust and physician's ability to treat the patient with "concern, empathy, honesty, tact and sensivity" (Donabedian, 1988).

Physicians also tend to balance between efforts to control costs, their own judgment about the best way of treatment and demand to consider the values of patient while making the treatment choices (McGlynn, 1997). Those three things do not always lead to the same conclusion. Cost control frequently is achieved as third parties make decisions about what services will be covered and what types of providers can offer those services. The involvement of the third parties may diminish the importance of physician judgment and autonomy, which may lead physicians to conclude that the technical quality of health care is suffering.

Traditionally, health care professionals when talking about quality focused on the technical nature of health care events. The focus has been on the training and updated skills of the physicians and the nature of the actual medical outcome (O'Connor, Shewchuk and Carney, 1994). One of the most widely used conceptual framework for quality of health care was proposed by Donabedian (1980) and is known as the "structure-process-outcome" model. "Structure" assesses the quality of health care through a study of the settings in which care takes place. "Process" reflects the interaction between the patient and health care professional, and depends on technical and interpersonal excellence. "Outcome" considers whether a change in a patient's current and future status can be attributed to health care received (for more explicit explanation of the SPO model, see Piligrimiene, Buciuniene, 2005). In this model quality was viewed as technical in nature and assessed from the physicians' point of view. According to Lee et al. (2000), considering the potentially fatal and irrevocable consequences of malpractice in health care, in contrast to other service industries, it would be logical and desirable for physicians to hold such an attitude. Physicians define outcomes in terms of the biological status of the patient (for example, blood pressure, lung functioning, mortality), because these are the outcomes they can control. The broader definition of the results of medical care encompasses physical, emotional and social functioning. Efforts to use outcomes as the sole metric for health care quality evaluation ignores the fact that medical interventions (the process of care) affect the outcomes. And so, we cannot rely only on health outcomes when evaluating the health care quality.

From the provider's perspective, quality care implies that he or she has the skills, resources, and conditions necessary to improve the health status of the patient, according to current technical standards and available resources. The provider's commitment and motivation depend on the ability to carry out his or her duties in an ideal or optimal way. Providers tend to focus on technical competence, effectiveness, and safety. Just as the health care system must respond to the patients' perspectives and demands, it must also respond to the needs and requirements of the health care provider. In this sense, health care providers can be thought of as the health care system's "internal clients". They need and expect effective and efficient technical, administrative, and support services in providing high-quality care (Brown et al., 1992).

Manager's perspective on health care quality

Managers of health care organization are rarely involved in delivering patient care, although the quality of patient care is central to everything they do. Focusing on the various dimensions of quality can help to set administrative priorities. Health care managers must provide for the needs and demands of both providers and patients. Also, they must be responsible stewards of the resources entrusted to them by the government, private entities, and the community. Health care managers must consider the needs of multiple clients in addressing questions about resource allocation, fee schedules, staffing patterns, and management practices. According to Brown et al. (1992) managers tend to feel that access, effectiveness, technical competence, and efficiency are the most important dimensions of quality.

Jun et al. (1998) summarized the findings from the focus groups (consisted of physicians, managers and patients) as illustration of population similarities and differences with respect of health care quality. The authors found that patient groups displayed more similarities with the managers group and those groups focused heavily on functional quality attributes, while physician group focused on technical quality attributes. Responsiveness was a strong concern for patients. Communication was a key dimension of health care quality in all three groups. There was a sharp contrast between definitions of quality used by physicians and managers. Physicians see their role as that of performing according to the norms of the profession, while managers' focus on accomplishing financial and other mission-related goals of the institution.

The way of integration of different perspectives

The health care service quality evaluation must find a way, which encompasses expectations and needs of every party involved.

With reference to McGlynn (1997), a starting point is to make explicit what patients, health care professionals and managers value and regard as an essential mission of health care. Areas of agreement among these perspectives must define the central focus for quality measurement. Areas in which an objective is not shared by all groups but is not necessarily in conflict with other expectations should be incorporated into the quality measurement system next. Areas of direct conflict require solutions outside the quality assessment arena.

Historically the literature suggests that physicians in general put more emphasis on medical outcomes than on either patient perceptions of process or structural determinants of health care quality. Patients, it is believed, determine health care quality mainly from the functional

determinants, as they are less empowered to judge technical quality. Administrators are driven by financial considerations to emphasize patient satisfaction as a measure of quality because patient satisfaction is believed to be central to effective marketing of a health care organization.

It is now possible to combine patient perceptions with quality measures derived from other sources, such as clinical or administrative databases or medical record review, to achieve a more comprehensive and useful measure of overall quality (Bowers and Kiefe, 2002).

Taking into consideration those quality aspects that are important to every group discussed above, we can identify some essential health care quality dimensions, which should be included into the comprehensive quality evaluation process.

The analysis of scientific literature revealed that the most important health care quality dimension for patients (health care providers had also already acknowledged its importance) might be generally called as "interpersonal relations" (this term has its theoretical justification – Brown et al., 1992). The dimension of interpersonal relations refers to the interaction between providers and patients, managers and health care providers, health institution and the community. Good interpersonal relations establish trust and credibility through demonstration of respect, confidentiality, courtesy, responsiveness and empathy. Effective listening and communication are also important. Inadequate interpersonal relations can reduce the effectiveness of a technically competent health service. Other terms, like "responsiveness" – willingness or readiness of employees to provide service (Parasuraman et al., 1985; 1988) or "patient centeredness" - the degree to which a system actually functions by placing the patient/user at the center of its delivery of healthcare and is often assessed in terms of patient's experience of their health care (Kelley and Hurst, 2006) are used to describe this dimension. Dimension of "interpersonal relations" includes all the aspects of functional quality that are important to patients and usually are evaluated employing the SERVQAUL scale, except of the dimension "tangibles".

"Tangibles" (Parasuraman et al., 1985; 1988) or "amenities" (Brown et al., 1992) refer to the features of health services that do not directly relate to clinical effectiveness but may enhance the patient's satisfaction and willingness to return to the facility for subsequent health care needs. Amenities are also important because they may affect the patient's expectations about and confidence in other aspects of the service. Tangibles relate to the physical appearance of facilities, personnel and materials, as well as to comfort, cleanliness and privacy. This conforms to the element "structure" in Donabedian's conceptualization of health care quality.

"Technical competence" refers to the skills, knowledge, capability and actual performance of health care providers, managers and support staff. Technical competence relates to how well providers execute practice guidelines and standards in terms of dependability, accuracy, reliability and consistency (Brown et al., 1992). For health care providers it includes clinical skills related to preventive care, diagnosis, treatment and health counseling. Competence in health management requires skills in supervision, training and problem solving. The requisite skills of support staff depend on individual job descriptions. "Competence" is very important dimension for health care professionals and represents the degree, to which health providers has training and abilities to diagnose, treat and communicate with patients. There are many potential aspects of competence in this context, including technical competence as well as cultural competence (Kelley and Hurst, 2006).

"Accessibility" is the ease with which health services are reached. Access can be physical, financial or psychological, and requires that health services are *a priori* available (Kelley and Hurst, 2006). Organizational access refers to the extent to which services are conveniently organized for clients, and encompasses issues as clinic hours and appointment systems, waiting time and the mode of service delivery (Brown et al., 1992).

The dimension of "safety" means the degree to which health care processes avoid, prevent, and ameliorate adverse outcomes or injuries that stem from the processes of health care itself (Kelley and Hurst, 2006). Safety means minimizing the risks of injury, infection, harmful side effects or other dangers related to service delivery. Safety involves the provider as well as the patient (Brown et al., 1992).

A key dimension is "effectiveness" which is the degree of achieving desirable outcomes, given the correct provision of evidence-based healthcare services to all who could benefit, but not to those who would not benefit (Arah, et al. 2003; WHO, 2000). Donabedian stresses that effectiveness is the extent to which attainable improvements in health are, in fact, attained (Donabedian, 2003; Donabedian 1980). Juran and other authors cite effectiveness as the degree to which processes result in desired outcomes, free from error (Juran and Godfrey, 2000). Effectiveness is an important dimension of quality at the central level, where norms and specifications are defined. Effectiveness issues should also be considered at the local level, where managers decide how to carry out norms and how to adapt them to local conditions.

"Efficiency" of health services is an important dimension of quality because it affects service affordability and because health care resources are usually limited. Efficient services provide optimal rather than maximum care to patient and community; they provide the greatest benefit within the resources available (Brown et al., 1992). "Efficiency" is the system's optimal use of available resources to yield maximum benefits or results. It speaks to a system's ability to function at lower costs without diminishing attainable and desirable results (Donabedian, 2003).

"Outcomes" is the essential element in health care service quality. Usually this dimension was treated as exclusively health care provider's prerogative when evaluating the quality of health care services. But now is obvious that outcomes in part can be also evaluated by patients. Outcomes can be defined as the change in a patient's health status that may be attributed to the medical care provided (Turner and Pol, 1995; Ward et al., 2005). As this dimension represents the technical quality, such terms like "core medical service" (Haywood-Farmer and

Stuart, 1988; Lee et al., 2000), "patient outcomes" and "patient satisfaction" (Bowers et al., 1994; Jun et al., 1998) might be used as synonymous. Considering the exceptional importance of this dimension, outcomes should be evaluated by all groups in health care institution: physicians evaluate outcomes according to clinical benchmarks, managers – according to financial, mission related goals of institution, and patients – according to their perceptions of cure.

Conclusions

We can conclude that in order to define quality, it is not enough to look at structured or statistical methods for doing so. The concept of quality has many dimensions, some of which are difficult to quantify, but no less essential to its definition. This article identifies that there are several key players in the processes of defining and measuring quality and voices of every party provide the important components to the process. We should incorporate these components into a more comprehensive way of service quality measurement and management. As functional aspects of quality are especially important to patients, technical aspects are essential for health care professionals, and other aspects, such as effectiveness, efficiency are of primary importance to managers, all off them should be included into the process of health care quality evaluation.

Analysis of different perspectives on health care quality allowed distinguishing the following quality dimensions, that are considered to be the most important for each party involved in the quality measurement: 1) "Interpersonal relations" – refers to the interaction between service providers and recipients through establishing trust, credibility, demonstration of respect, confidentiality, courtesy, responsiveness, empathy and effective communication; 2) "Tangibles" refers to the features of health services that do not directly relate to clinical effectiveness but may enhance the patient's satisfaction and willingness to return to the facility for subsequent health care needs. Tangibles relate to the physical appearance of facilities, personnel and materials, as well as to comfort, cleanliness and privacy; 3) "Technical competence" refers to the skills, knowledge, capability and actual performance of health care providers, managers and support staff, i.e., the "must be" features of health care service; 4) "Accessibility" - the ease with which health services are reached, i.e., clinic hours, waiting time, etc.; 5) "Safety" - minimizing the risks of injury, infection, harmful side effects or other dangers related to service delivery. Safety involves the provider as well as the patient; 6) "Effectiveness" is the extent to which attainable improvements in health are, in fact, attained; 7) "Efficiency" is the system's optimal use of available resources to yield maximum results; 8) "Outcomes" can be defined as the change in a patient's health status that may be attributed to the medical care provided. "Outcomes" is the essential element in health care service quality, but for a long time it was treated as exclusively health care providers' prerogative when evaluating the quality of health care. The truth is that "outcomes" can be evaluated by patients as well, for at least in some part. That's why this dimension should be evaluated by all three identified groups (patients, physicians and managers) in the health care institution. Just the evaluation of every group might be reasoned on different aspects, according to the competence required and the point of reference.

Limitations and directions for future research

This study limited its research scope to the key perspectives on health care quality at the level of health care institution. Health care quality can also be studied as the issue related to the entire health care system. In that case, other very important health care quality dimensions, irrespective of ones, we already discussed, should be brought in the fore, for example, "equity".

The future task is to make one, coherent operational instrument, that would allow to measure health care service quality in a way, that provide real benefit to quality improvement, embracing the quality dimensions, important to all three parties at the health care organization.

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Skirtingi požiūriai į sveikatos priežiūros kokybę: ar įmanomas konsensusas?

Santrauka

Kokybės vertinimas ir valdymas šiandien yra viena svarbiausių paslaugų srities, taip pat ir sveikatos priežiūros temų. Kokybės vertinimo poreikis vis didėja, kadangi pastangos sumažinti kaštus ir restruktūrizuoti sveikatos priežiūrą tęsiasi. Įvairių sričių ekspertai ištisus dešimtmečius stengiasi suformuluoti išsamų, bendrai priimtiną sveikatos priežiūros kokybės apibrėžimą. Tačiau iš esamų apibrėžimų įvairovės tampa akivaizdu, kad yra keletas perspektyvų į sveikatos priežiūros paslaugas, kuriomis sveikatos priežiūros paslaugų kokybė gali būti nagrinėjama. Pacientai, paslaugų teikėjai ir kitos šalys, susijusios su sveikatos priežiūra, supranta ir apibūdina paslaugų kokybę skirtingai. Skirtingi požiūriai į sveikatos priežiūros paslaugų kokybę logiškai veda prie skirtingų metodų kokybei vertinti ir valdyti naudojimą.

Atsižvelgiant į aukščiau išdėstytus aspektus, šio straipsnio problema suformuluota kaip klausimas: ar įmanomas konsensusas tarp skirtingų perspektyvų į sveikatos priežiūros kokybę?

Straipsnio tikslas – išanalizuoti skirtingus požiūrius į sveikatos priežiūros kokybę organizacijos lygmenyje ir nustatyti kokybės dimensijas, svarbias pacientams, sveikatos priežiūros profesionalams ir vadovams, kad kokybės vertinimas apimtų visiems svarbius kokybės aspektus.

Tyrimo objektas – skirtingi požiūriai į sveikatos priežiūros kokybę, priklausomai nuo vertintojo sveikatos priežiūros organizacijos lygmeny.

Tyrimo metodai – sisteminė ir lyginamoji mokslinės literatūros analizė.

Daug pastangų buvo skirta siekiant suformuluoti išsamų ir bendrai priimtiną sveikatos priežiūros paslaugų kokybės apibrėžimą. Donabedian (1980) sveikatos priežiūros paslaugų kokybę apibrėžė kaip „tokią priežiūrą, kuri padidina paciento gerovę, kai yra įvertintas balansas tikėtinų laimėjimų ir praradimų, kurie lydi sveikatos priežiūros procesą kiekvienoje iš jo dalių". 1984m. Amerikos Medicinos Asociacija apibrėžė sveikatos priežiūros paslaugų kokybę kaip priežiūrą, kuri „nuolat veikia pagerinimą arba palaikymą gyvenimo kokybės ir (arba) jo trukmės" (Blumenthal, 1996). Asociacija identifikavo specifines sveikatos priežiūros savybes, kurias tenka tirti nustatant jos kokybę, įskaitant visuomenės informavimą sveikatos temomis (žiniasklaidos priemonėmis), ligų prevenciją, atlikimą laiku, pacientų dalyvavimą, jų informuotumą, dėmesį moksliniam medicinos pagrindui ir efektyvų resursų naudojimą. Kokybė taip pat buvo apibrėžiama kaip „sugebėjimai pasiekti trokštamų tikslų naudojant įstatymais numatytas priemones", kur trokštami tikslai reiškia „pasiekiamą sveikatos lygmenį" (Donabedian, 1988). Taigi, kokybė yra pasiekiama kai gydytojas tinkamai padeda savo pacientui pasiekti pasiekiamą sveikatos lygį. Europos Standartizavimo Komitetas (1994) pateikia dar labiau apibendrintą apibrėžimą: „Kokybė yra vieneto charakteristikų visuma, kurios įgalina patenkinti išreikštus ar naujai atsirandančius poreikius" (Helminen, 2000). Toks apibrėžimas leidžia įtraukti tiek paslaugų teikėjo, tiek ir paciento lūkesčius, kai kalbama apie sveikatos priežiūros paslaugų kokybę. Kita vertus, Ovretveit (1992) apibrėžia kokybę kaip „pilnutinį poreikių patenkinimą tų, kuriems paslauga yra reikalingiausia, mažiausiais ištekliais organizacijai, pagal nurodytas direktyvas ir ribas, nustatytas aukštesniųjų institucijų bei vartotojų". Vienas iš plačiausiai vartojamų sveikatos priežiūros kokybės apibrėžimų buvo pasiūlytas Medicinos instituto (JAV) (1990); čia sveikatos priežiūros paslaugų kokybė apibrėžiama kaip „laipsnis, kuriuo sveikatos priežiūros paslaugos individams ir visuomenei padidina trokštamų sveikatos rezultatų tikimybę ir atitinka naujausias profesionalias žinias" (IOM, 1990). Šie skirtingi kokybės apibrėžimai rodo, kad yra keletas skirtingų požiūrių į sveikatos priežiūros kokybę, ir priklausomai nuo to, kas tą kokybę vertina, iškyla vis kitų svarbių kokybės dimensijų.

Pacientai yra linkę vertinti sveikatos priežiūros paslaugų kokybę, atsižvelgdami į atitinkamą reagavimą į jų individualius poreikius. Dauguma pacientų kokybę apibrėžia kaip gydytojų pastangas daryti viską, kas įmanoma, norint padėti pacientui. Dažniausiai skiriama dėmesio tokioms kokybės dimensijoms kaip efektyvumas, prieinamumas, tarpasmeniniai santykiai, tęstinumas ir apčiuopiamumas. Tačiau pastebima, kad pacientai dažnai nevisiškai supranta savo sveikatos poreikius ir negali tinkamai įvertinti techninės gydytojų kompetencijos. Plačiausiai naudojamas instrumentas paslaugų kokybei tirti pacientų požiūriu yra SERVQUAL skalė (Parasuraman, Zeithaml ir Berry, 1985; 1988), apimanti tokias kokybės dimensijas kaip patikimumas, garantija, reagavimas, empatija ir apčiuopiamumas. Išskyrus apčiuopiamumą, kuris atspindi struktūrinius paslaugų kokybės elementus (fiziniai patogumai, materialių išteklių buvimas ir išvaizda), kiti SERVQUAL elementai daugelio autorių nuomone, atspindi funkcinę paslaugų kokybę, t.y. tai, kaip paslaugos yra teikiamos.

Sveikatos priežiūros paslaugų teikėjai (profesionalai) kokybę apibrėžia, remdamiesi suteiktos priežiūros savybėmis ir rezultatais, kas veda prie kokybės apibrėžimo, akcentuojančio techninį tobulumą (kokybę), kuriuo priežiūra yra teikiama, ir gydytojo/paciento tarpusavio sąveikos charakteristikas. Tradiciškai susiklostė nuomonė, kad gydytojams ir kitiems sveikatos priežiūros paslaugų teikėjams, svarbiausias kokybės vertinimo dalykas yra sveikatos rezultatai, pasiekiami teikiant profesinius standartus atitinkančias sveikatos paslaugas. Tačiau pastaruoju metu ir profesionalai jau suprato pacientų vertybių ir pasitenkinimo svarbą, todėl pradėta daugiau dėmesio skirti ir santykiams tarp gydytojo ir paciento. Medicinos atstovai kokybei vertinti dažniausiai pasitelkia Donabedian (1980) pasiūlytą „struktūros-proceso-rezultato" kokybės koncepciją.

Sveikatos priežiūros organizacijos administratoriai (vadovai) dažnai linkę kokybę apibūdinti atsižvelgiant į teikiamų paslaugų efektyvumą ir produktyvumą, vertindami ne tik gerus sveikatos rezultatus, bet ir optimalų finansinių ir kitų išteklių panaudojimą geriems rezultatams pasiekti. Keletas atliktų tyrimų (pvz., Jun ir kt., 1998) parodė, kad pacientų nuomonė apie sveikatos priežiūros paslaugų kokybę ir įvairias jos dimensijas turi daugiau panašumų į vadovų nuomonę, kurie taip pat linkę daug dėmesio skirti pacientų pasitenkinimui, ir šios grupės didesnį dėmesį skiria funkcinės kokybės dimensijoms, tuo tarpu gydytojai labiau koncentruojasi į techninius kokybės aspektus ir kokybę supranta kaip veiklą, atitinkančią profesines normas.

Išanalizavus skirtingus požiūrius apie sveikatos priežiūros paslaugų kokybę, straipsnyje išskirtos kokybės dimensijos, apimančios visoms trims grupėms (pacientams, gydytojams ir vadovams) svarbius sveikatos priežiūros paslaugų kokybės aspektus. Apibendrinant mokslinės literatūros analizės rezultatus, teigiama, kad sveikatos priežiūros paslaugų kokybės vertinimas turi apimti šias kokybės dimensijas: 1) „tarpasmeniniai santykiai“ – atspindi sąveiką tarp paslaugų teikėjų ir gavėjų, įtraukiant tokius aspektus kaip pasitikėjimo kūrimas, pagarba, konfidencialumas, paslaugumas, reagavimas, empatija, išklausymas ir komunikacija; 2) „apčiuopiamumas“ – atspindi paslaugų savybes, kurios nėra tiesiogiai susijusios su klinikiniu paslaugų efektyvumu, tačiau gali padidinti pacientų pasitenkinimą ir ateities ketinimus organizacijos atžvilgiu. Tai yra fiziniai patogumai, personalo ir informacinės medžiagos buvimas ir išvaizda, komfortas, švara ir pan.; 3) „techninė kompetencija“ – apima sveikatos priežiūros paslaugų teikėjų įgūdžius, žinias, kompetenciją, kurie yra būtini teikiant sveikatos priežiūros paslaugas; 4) „prieinamumas“ – lengvumas, kuriuo sveikatos paslaugos pasiekiamos, t.y. patogios organizacijos darbo valandos, laukimo trukmė ir pan.; 5) „saugumas“ – laipsnis, kuriuo sveikatos priežiūros procesai yra apsaugoti nuo galimų neigiamų pašalinių efektų rizikos susižeisti, užsikrėsti ar kaip kitaip pakenkti visiems, susijusiems su sveikatos priežiūros teikimu ir gavimu; 6) „efektyvumas“ – laipsnis, kuriuo trokštami sveikatos rezultatai yra iš tiesų pasiekiami; 7) „produktyvumas“ – optimalios paslaugos teikimas, t.y. didžiausios naudos su mažiausiais kaštais pasiekimo laipsnis; ir 8) „rezultatai“ – paciento sveikatos pokytis, kuris gali būti priskirtas suteiktoms sveikatos priežiūros paslaugoms. Šios paskutinės kokybės dimensijos, esminės sveikatos paslaugų sferoje, vertinimas ilgą laiką buvo laikomas paslaugų teikėjų prerogatyva, tačiau iš tiesų ją gali iš dalies įvertinti ir pacientai. Gydytojai vertina rezultatus remdamiesi klinikiniais standartais, pacientai – savo pačių nuomone apie savo sveikatą, o vadovai – remdamiesi finansiniais ar kitais organizacijos tikslais.

Kadangi pacientams svarbesni funkciniai kokybės aspektai, gydytojams – techniniai, o vadovams – su įmonės tikslais susiję rezultatai, visi jie turi būti įtraukti į kokybės vertinimo procesą.

Šiame straipsnyje apsiribojama pagrindinėmis perspektyvomis į sveikatos priežiūros kokybę organizaciniame lygmenyje. Sveikatos priežiūros kokybė taip pat gali būti analizuojama visos sveikatos priežiūros sistemos lygmenyje. Tokiu atveju atsirastų daugiau svarbių kokybės dimensijų, (pvz., teisingumas, lygybė), kurias būtų privalu analizuoti.

Raktažodžiai: *sveikatos priežiūros kokybė, pacientų požiūris, gydytojų požiūris, vadovų požiūris į kokybę.*

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Brand Valuation: Viewpoint of Customer and Company

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The article consists of five parts, where the first part formulates the problem, aim and research methodology.

The aim of the article is to prepare integrated economic brand valuation model on theoretical layer analysis and summary of brand valuation models and to test it empirically.

The article analyzes the problem how to prepare integrated brand valuation model which enables thorough estimation of brand value in viewpoint of customer and company.

The second part of the article presents substantiation of brand valuation and theoretical studies of brand valuation models. Analyzing traditional economic brand valuation models the results of theoretical and empiric researches by authors who study these models are presented. In summary it could be stated that traditional economic brand valuation models estimate only material brand value form and ignore customer influence on brand value. Nonfiction literature presents psychographic and behaviorally oriented brand valuation models. Aaker (1991), Kapferer (1992), Keller (1993) and Mckinsey (1994) present brand valuation models where user, user attitude and behavior are in focus. This article presents composite economic and behaviorally oriented brand valuation models, which unite both economic and psychographic factors. Though composite economic and behaviorally-oriented models reflect brand valuation influencing factors more detailed, still more economic, financial and behaviorally-oriented factors integrating model are missing.

After completing theoretical studies of brand valuation models it can be stated that some model only estimate material brand value (economic brand valuation models), others uncover customer attitudes and behavior in brand valuation (psychographical and behaviorally-oriented brand valuation models), and still others mostly estimate material brand value also taking into account customer behavior in the viewpoint of brand value. In the third part of the article on the ground of theoretical study of brand valuation model the integrated brand valuation model is prepared. This model unites economic, psychographic and behaviorally oriented brand valuation models. Integrated brand valuation model mostly measures brand value on the ground of economic brand valuation models. According to this model, brand value is measured from two positions: customer and company.

The results of the empirical study of brand valuation are presented in the fourth part of the article. The results of empirical research have been received by quantitative survey using questionnaire. The aim of empirical research is to identify a common factor which influences brand value and according to this rate, existing "Ūkio bankas"as brand value in customer attitude. The summary of the results ant the recommendation for "Ūkio bankas" as brand valuation is presented after the empirical study of "Ūkio bankas" as brand valuation.

The last part of the article provides the final conclusions and recommendations for brand valuation.

Keywords: *brand, brand value, models of brand equity valuation.*

Introduction

In intense situation of rivalry it is important not only to stand out rivals but also to do this by offering exclusive value of product. This can be made by creating brand value, which creates value of product to customer. However it is not enough only to create brand value. A very important action of business subject brand operation is brand valuation. Brand valuation can be fulfilled by applying several models of brand valuation.

The problem. Scientific and empirical researches of brand valuation are made by such scientists as Kapferer (1997, 2003), de Chernatony (1999, 2001), Aaker and Joachimsthaler (1997, 2003), Keller (1993, 1998), Melin (1997), Upshaw (1995) Gudaciauskas (2001), Piesarskas (2002) and others, but in this area there is a lack of singleness and wholeness in pursuance of measuring brand equity.

In nonfiction literature most attention is paid to only traditional economic or behaviorally oriented brand value models. However economic brand value models are studied insufficiently. There are insufficient conceptually reasoned brand valuation models, which would integrate those models and make it available to measure brand value. The *pending problem* in the article is related to preparing and empirical substantiation of integrated model of brand valuation.

The aim of the article – to prepare integrated brand valuation model on theoretical layer analysis and summary of brand valuation models and to test it empirically using "Ūkio bankas" as brand for example.

Research methodology includes systemic and comparative literature analysis, secondary data analysis and quantitative studies. The quantitative studies employ the method of a questionnaire survey.