SERVQUAL Method as an “Old New” Tool

Subjects: Health Care Sciences & Services

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The SERVQUAL model, which is a research tool, determines the relative impact of five dimensions, namely, tangibility, reliability, responsibility, confidence, and empathy, on customer perception. In the medical field, an efficient identification of errors in the process of creating and providing services is conducive to high quality. The SQ method basically refers to gap 5, the last one in the above list, combining service quality design from the customer’s point of view, where the customer is also the service provider. Service evaluation is carried out by means of a questionnaire/survey, dedicated to this method and regarded as a measurement tool. The Servqual method enables to learn the patient's expectations, while the service provider can identify irregularities and implement corrections. It allows the executive staff of medical facilities to change elements of medical procedures, which improves the quality of the service provided and thus increases satisfaction and compliance of patients.

service quality SERVQUAL

1. Introduction

The second half of the 20th century saw the development of a new trend in the management of medical services across Europe. Those changes were associated with the transformation of various spheres of human life, both on professional and private levels. The service market then turned back to “quality”, already known in antiquity. According to Aristotle, “quality” is one of the basic categories of thought and reality of the human population.

Currently, according to the International Organization for Standardization (ISO), “quality” is “the totality of properties of a product or service that determine its to meet identified or anticipated needs.” “Quality” is a comparison between expectation and performance or the obtained effect [1]. According to Opolski K. et al., quality is an objective goal that should be pursued [2][3].

“Quality” consists of all the elements of a product, including services that contribute to the satisfaction of a potential customer. Human health care requires the highest quality at every level of services provided. Taking into account the WHO’s definitions of medical service quality, Opolski et al. claim that the quality of medical services provided should be determined by the highest professional competence and dedication that meet the patient’s expectations [2][3]. The quality of medical services can be evaluated in the following two areas: clinical (postulated) quality and perceived quality. The clinical quality of services reflects an objective medical outcome. In turn, the perceived quality is related to the patient’s subjective awareness about the manner in which he/she was contacted, cared for, or shown interest at a medical facility [2][3]. According to Opolski and the team, an important component of the aforementioned quality, i.e., perceived quality, is the patient’s perception of staff competence level, as well as of the

convenience and aesthetics of the medical institution [2]. Human health and life quality levels, resulting from high standards of medical services offered and provided on the market, are further important aspects of the quality of medical services.

Another aspect of the quality of medical services is also extremely important, namely, the level of human health and life as an effect of the quality of the service provided on the medical market. The level of human health and life is the final result of the quality of the service provided on the medical market. The Servqual method fits in with the quality of service management models. There are many models of service quality management, i.e., a series of more or less tangible activities taking place during the interaction between the client and the service provider that are delivered as a solution to the client’s problems. Among them, the concepts of Gronroos, Gummesson, and Berry should be mentioned. They all assume that service quality is the result of the quality expected and obtained. The Servqual (SQ) model, an acronym from the words “service” and “quality”, is based on these premises.

2. Servqual: Description and Meaning

SQ, designed to assess service quality and based on standardized parameters, was developed by Zeithamlai, Parasuraman, and Barry for the non-medical sector in 1985 [4].

The authors of the method assumed the existence of gaps (discrepancies) between the levels of service provided and service expected. When a customer’s expectations exceed his/her own real experiences a difference in service quality emerges. An identification of such discrepancies/gaps may help eliminate the dissonance between the level of a customer’s expectations and patient perceptions of service provided, which, in turn, may contribute to increased customer satisfaction and thus improve the quality of service [5]. The quality of the provided medical procedures has priority over other elements of the service (material components of the service, e.g., the technical condition of the building) and is treated as a priority. Quality takes precedence over other elements of service provided and is thus given a priority. The SQ gap model enables the identification of five gaps/discrepancies and the factors that relate to them, making it possible to determine the service quality provided. SQ is therefore intended to assess the level of customer satisfaction with service quality in various sectors or industries [6].

According to Parasuraman A et al., five gaps are distinguished.

The first gap relates to the differences between customer expectations and the perceptions of a generating entity (service providers) towards the needs of customers (e.g., patients). The size of the gap is influenced by marketing research, carried out by a given entity.

The second gap relates to the contradiction between the concept of the service and its factual characteristics. The size of this gap depends on the management’s commitment to service quality issues and setting goals, as well as the standardization of tasks and the perception of opportunities.

The next, the third, gap relates to discrepancies between the service provided and the specificity concerning the creation of the quality of services. The size of this gap depends on teamwork, as well as on the matching of employees to entrusted work, technology, and the perception of control, as well as the supervision and control system.

The fourth inconsistency is the difference between promised and delivered service. The size of this gap is influenced by horizontal communication as well as by tendencies to inflate promises.

The last, the fifth, gap results from the previous gaps, being the difference between what the client (e.g., patient) expects and what he/she receives [4]. The sizes of the above-mentioned gaps are influenced by various factors, including the commitment of manager and employees, marketing research, standardization of activities, the perception of customer requirements, and contacts with the customer. Hence, the comparison of expectations and the perception of service quality give an answer to the question of how service quality is perceived by the customer [6].

The first figure shows a simplified diagram of the SQ method (**Figure 1**).

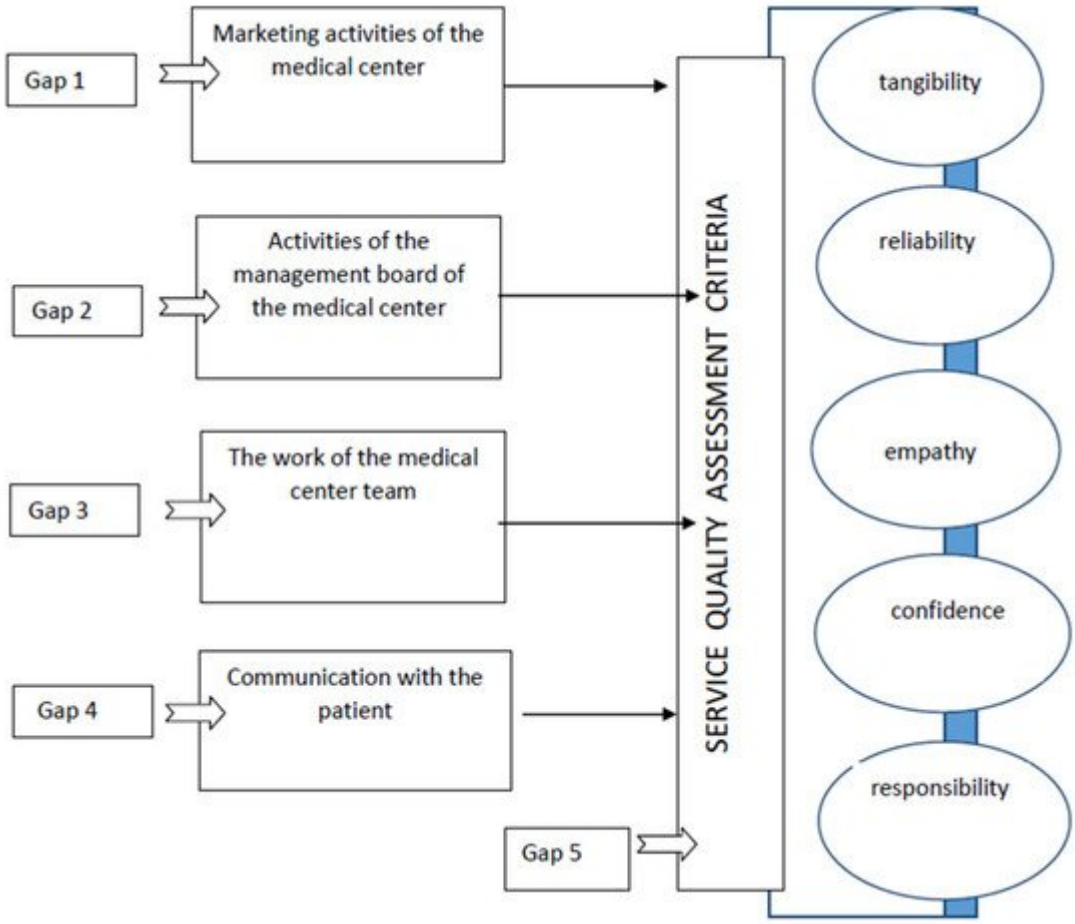


Figure 1. Quality gap model, on the basis of Parasuraman A. et al. “A Conceptual Model of Service Quality and Its Implications for Future Research” [4], used with the permission of the publisher of the original article.

The SERVQUAL model, which is a research tool, determines the relative impact of five dimensions, namely, tangibility, reliability, responsibility, confidence, and empathy, on customer perception [4]. In the medical field, according to Szyc et al., an efficient identification of errors in the process of creating and providing services is conducive to high quality [7]. The SQ method basically refers to gap 5, the last one in the above list, combining service quality design from the customer’s point of view, where the customer is also the service provider. Service evaluation is carried out by means of a questionnaire/survey, dedicated to this method and regarded as a measurement tool.

3. Limitations in Servqual Method

Some researchers point to some limitations of the Servqual method and emphasize that it does not show consistent results in terms of the internal content of the scales [4][8][9][10][11]. At the root of these discrepancies there are, among others, cultural differences in the way people understand and give meaning to the social world and medical care [2][3]. Babakus and Boller indicate that SQ is characterized by a poor fit, and the obtained results do not meet the more stringent convergence criteria and contribute to the discrimination of specific variances [12]. In their opinion, SQ can only be used to develop a one-dimensional assessment of the quality of services and not their multi-dimensional assessment. These authors also point to necessary caution when interpreting obtained results by means of different scales, as the results may be distorted. Furthermore, the formulation and definition of the context of the results, obtained by the Servqual method, may also be a problem [12]. A critical look at the Servqual method is also presented by Van Dyke et al. [9]. They indicated that the difficulties, related to the application of the method, could be divided into four categories. The first category includes problems with using differences or vulnerability points. The second category is the allegation of the model credibility, and the third one is an ambiguous definition of the concept of “expectation”. The last, i.e., the fourth, category addresses the unstable dimensionality of the Servqual instrument.

Cwiklicki believes that this model does not work, among others, for the services linked to a product [8]. The author emphasizes that the quality of services, provided in individual dimensions, can be grouped according to the criteria of the degree of meeting customer expectations. The scale (high, medium and low) corresponds to the size of the gap [8]. Other reservations concern, inter alia, the use of the same questionnaire for different types of services, the discrepancy between expectation and perception cannot be obtained by measuring only the perception of clients, or blurring the difference between the subjectivity of feeling and the mastery of execution [11][13].

Interesting enough are the insights of Mauri et al., who analyzed nearly 30 years of research of a gap model in international academic databases. However, despite some critical theoretical–conceptual and methodological–operational aspects, the gap model and the SERVQUAL scale are still the most frequently used instruments for service quality studies, met in marketing literature [14]. The medical service market is highly specific, being, on the one hand, the subject of market regulations (supply/stay), and of the market rules of competition for patients, on the other. The basic feature of medical service is its immateriality, as shown by the SQ model, together with the identification of several implications for the management of medical facilities.

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