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STUDY ON THE GAP BETWEEN HOSPITAL POLICY, PRACTICE AND SERVICE LEVELS

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Abstract

One of the most important problems that has an impact on the quality of healthcare that is provided is the disparity that exists between hospital policy, practice, and service levels. The purpose of this study is to investigate the elements that contribute to divergences between the policies that have been set by the hospital, their execution in practice, and the service levels that have thus resulted. The research identifies significant areas where misalignment occurs by conducting a comprehensive analysis of the available literature, conducting case studies, and conducting field observations among other methods. It emphasizes the significance of communication that is both clear and consistent, ongoing education and training, proper resource allocation, comprehensive monitoring and evaluation mechanisms, and an approach that is centered on the patient. After doing the research, the researchers came to the conclusion that in order to bridge these gaps, a holistic strategy that includes strong leadership, a culture of accountability, and ongoing engagement among all stakeholders is required.

Keywords : *Hospital, Policy, Service*

INTRODUCTION

A crucial problem in healthcare administration is the disparity that exists between hospital policy, practice, and service levels. This gap exposes the differences that exist between accepted standards, real clinical practices, and the calibre of treatment provided to patients. Hospital rules are carefully crafted to offer a uniform foundation guaranteeing excellent treatment, legal compliance, and smooth operations. These policies include a wide range of topics related to the provision of healthcare, such as administrative processes, clinical recommendations, and patient safety regulations. But putting policy into practice is frequently a difficult process. Clear and well-meaning policies may not always be implemented as intended due to a variety of reasons, including a hospital's organisational culture, staff training disparities, and resource limitations. In actuality, these elements may cause notable departures from set guidelines, producing uneve.

Resources are one of the main factors behind this disparity. Hospitals frequently struggle with staffing, equipment, and budgetary constraints, which makes it difficult for them to carry out policies completely. For instance, it may be challenging to uphold a policy that calls for a particular nurse-to-patient ratio for the best treatment during times of high patient volume or financial constraints, which could result in overworked personnel and subpar patient care. Additionally, even within the same hospital system, differences in the quality of care might arise from differences in access to cutting-edge medical technologies and medications. The discrepancy between policy and reality is further exacerbated by variations in staff competency and training. Although hospital regulations may require healthcare providers to undergo regular training and certification, there may be variations in the way these programmes are actually implemented. It's possible

that insufficient onboarding will be provided to new hires, or that possibilities for continued professional development may be restricted because of time or budgetary constraints. This may result in disparities in the quality of treatment provided, with some staff members rigorously following procedures while others might not be completely up to date on best practices or new recommendations.

An important factor in this disparity is organisational culture as well. Effective policy implementation may be hampered by a culture that values hierarchy and opposes candid communication. Frontline employees may be reluctant to raise issues concerning real-world difficulties or to recommend changes to current protocols in such settings. On the other hand, a supportive workplace environment that values collaboration, ongoing education, and candid communication can greatly improve the congruence between practice and policy. Hospitals that promote a culture of safety and quality enhancement typically see greater patient satisfaction and better adherence to established policies.

Another big problem is the inconsistent application of evidence-based methods. It might be difficult to incorporate strong clinical recommendations and research into routine practice, even though they are readily available. Adoption of best practices can be hindered by a number of factors, including infrastructural deficiencies, lack of access to the most recent research, and opposition to change. For instance, although a policy may recommend using particular protocols to manage sepsis, in practice, this may not always be the case because of inefficiencies in workflow, variations in provider understanding, or lack of access to essential resources.

A diversified strategy is needed to address these problems. Finding gaps and areas for improvement requires constant monitoring and assessment. Regular audits, performance evaluations, and the measurement of policy compliance using key performance indicators (KPIs) are a few ways to do this. Feedback tools, including as staff feedback, patient satisfaction surveys, and incident reporting systems, can identify areas that require attention and offer insightful information on how effective policies are.

OBJECTIVES

1. To examine how Service Quality is measured in relation to the chosen hospitals.
2. To assess the level of service at a few chosen hospitals and determine the causes of any deficiencies.

OVERVIEW OFHEALTHCARE SYSTEM IN INDIA

Although it is the responsibility of the government in every nation to provide high-quality health care to the general public and a fundamental requirement, the scope and structure of health care services vary from country to country due to factors such as the economic climate, political system, geography, ever-changing health issues at the local, national, and state levels, and most importantly, the availability of resources that are appropriate for the situation. In the process of building a national health care system, it is of the utmost importance to take into consideration the values and objectives represented by both patients and medical experts. These basic issues are not the only factors that impact the use and delivery of healthcare services; social and cultural factors also play a crucial role. The provision of medical care is seen as a basic human right in some countries; thus, members of the population in these nations have access to publicly sponsored medical services that are controlled and supervised by the government. On the other hand, in nations where health care is seen as a commodity, the private sector plays a more significant role in the provision of this service, and customers have the ability to shop about for the best possible offer. Although health care is recognized as a basic human right in India and the public and private sectors collaborate to offer it, the enormous population of the nation, which exceeds 125 crore, makes it difficult for the government to satisfy the requirements of each and every individual in terms of medical treatment. Through the year 2020, it is anticipated that the health care industry in India would have reached a potential value of $290 billion,

making it one of the most significant contributors to the Indian economy. The sector is expanding at a pace that is exponential, which is resulting in an increase in both numbers of employment and revenue. This expansion may be attributed to a number of factors, including expanding populations, more disposable income, and more stable governments. There is a wide range of potential causes for this phenomenon, some of which include the increase in lifestyle-related disorders and the broadening of health insurance coverage. There is a significant increase in the number of medical tourists, despite the fact that the government only allocates a tiny portion of its GDP to healthcare institutions. In light of the fact that this enormous number of visitors has the potential to bring in a substantial amount of income for the healthcare industry, there is an immediate need to develop multi-specialty and tertiary care institutions that are capable of delivering the highest possible level of services to these tourists. Because of the ease with which individuals may access information technology and the growing awareness of health issues among the general population, the amount of money spent on health care has grown accordingly.

The Indian government is responsible for the supervision and management of health care as a matter of state. It is the obligation of governments to promote public awareness and offer both therapeutic and preventive services. In addition to establishing the required infrastructure, it is also their responsibility to deliver these services. Furthermore, according to the Medical Council Act of 1970, the government has the authority to make decisions about the formation of health facilities, regardless of whether they are educational or curative in nature. These decisions must be made in line with the needs of society.

RESEARCH METHODOLOGY

The selection of the sample, which includes the selection of respondents, the selection of the sampling technique that will be employed, and the layout of the questionnaire, is the subject of this section of the study.

SAMPLE SELECTION

Selection of Hospitals

When it comes to selecting the hospitals to study in the geographical area of Hyderabad city, which is located in the state of Andhra Pradesh, which is located in the country of India, the list of hospitals is not only not very extensive, but it also required serious thought and consideration. Here is a list of the different types of hospitals that are available.

1. Hospitals that are owned and operated by corporations, which are typically separated from private hospitals by differences such as the range of medical specialties they provide than private hospitals.
2. private hospitals
3. Hospitals that are part of public-private partnerships
4. Hospitals run by the government
5. Trust-based medical facilities

Here in Table 1you will find a list of the many hospitals that are under the jurisdiction of the government of AP, as well as the other hospitals that have been mentioned.

Table 1 : List of some prominent hospitals in Hyderabad

Sl. No	Hospital	Ownership	No. of Beds	Established
1	Aditya Hospitas	Private	150	1988
2	Apollo Hospitas	Private	4000	1979
3	Asian Institute cfGastroenterology	Private	150	2004

4	Aware Hospitds	Private	300	1975
5	Care Hospitals	Private	1400	1983
6	Durgabai Desrmukh Hospital	Trust	200	1962
7	Fernandez Hospital	Private	150	1948
8	Gandhi General Hospital	Government	1012	1954
9	Global Hospitds	Private	200	1998
10	Healing Touch Hospital	Private	120	1999
11	Herita e	Private	100	1994
12	Hope Children Hospital	Private	150	2001
13	Image Hospita s	Private	500	1998
14	Indo- American Cancer Institute & Research Centre	Trust	200	2000
15	Jayabhushan Hospital	Private	200	1972
16	Kamineni Hospitals	Private	150	1996
17	Krishna Children's Hos ital	Private	100	1985
18	Krishna InstituÉ of Medical Sciences	Private	500	2004
19	LV Prasad Eye Institute	Trust	250	1987
20	MNJ Institute cf Oncology	Government	250	1955
21	Manipal Hospi&l	Private	600	1989
22	Mediciti Hospital	Private	200	1995
23	Medwin Hospital	private	600	1955
24	M hri Multi S iality Hos ital	Private	350	1998
25	Nizam's Institute of Medical sciences	Semi Government	1030	1964
26	Osmania General Hospital	Government	3800	1846
27	Ram Hos ital	Private	450	1985
28	Rainbow Children's Hospital	Private	150	1999
29	Remed Super Specialty Hospital	Private	200	1995
30	SagarLaal Hospital	Trust	100	1974
31	Sarojini Devi Eye Hospital	Government	500	1956
32	St.Teresa's Hospital	Trust	200	1960
33	Sun Shine Hos ital	Private	150	1999
34	Usha Mullapudi Cardiac Centre	P.rivate	150	2001
35	Wockhardt Hospitals	Private	160	1989
36	Yashoda Hospitals	Private	980	1989

For the purpose of this investigation, the five hospitals that were chosen were chosen on the basis of a few essential considerations, which are detailed below. When it comes to qualifying the five hospitals for investigation and, as a result, contributing to the process of arriving at the final list, these requirements are considered to be reasonable and sufficient. Some of the parameters include:

Ownership The corporate sector has two hospitals, the semi-government sector has one hospital, and the government sector has two hospitals. The total number of available beds Hospitals with more than one thousand beds were the only ones chosen. Establishment of medical facilities Ten years of active service provision is a minimum requirement.

For the purpose of this study, the five hospitals that are listed below were chosen from among the potential hospitals that may be classified as belonging to all three groups together.

DATA ANALYSIS

A scale that could be used to measure service quality perceptions was established by Parasuraman et al. (1988)1 based upon a series of focus group interviews. This scale was designed in an effort to answer the problem of how to measure service quality. The scale was based on the utilization of 10 elements. In the beginning, the 10 components that were developed for the purpose of evaluating the quality of service were as follows: tangibles, reliability, responsiveness, competence, courtesy, credibility, security, access, communications, and understanding the customer. Additionally, additional research conducted by Parasuraman and colleagues (1988)2 resulted in a significant alteration that altered the dimensions that might be utilized to quantify the perceptions of service quality. provides a clearly displayed illustration of this adjustment, which reduces the ten elements to five elements. Among the original ten components, tangibles, reliability, and responsiveness were the only three that did not alter. These three characteristics are described in Table 2. Two elements were created by combining the remaining seven elements that were originally made. Those characteristics that are known as courtesy, credibility, and security were merged to make one of the new elements that is known as assurance. Additionally, the elements of access, communications, and understanding the customer were combined to form the new element that is known as empathy, as shown in Table 3. Now, the five components that comprised what the authors referred to as SERVQUAL were the five dimensions of service quality that are outlined in Table 3 These five dimensions are tangibles, reliability, responsiveness, assurance, and empathy. Using the five elements or dimensions as a foundation, they proposed that the quality of service might be evaluated by determining the disparity between the perceptions and expectations of those dimensions. After being provided with a number of questions, the client was asked to rate the specific choices they had made in relation to their expectations of service from the service provider.

Table 2: Definition of Original. Ten SERVQUAL Dimensions

Dimension and Definition	Questions Raised By Customers
Tangibles: Appearance of physical facilities, equipment, personnel, and communication materials.	Are the hospital's facilities attractive? Is my doctor dressed appropriately? Is my record sheet easy to understand?
Reliability: Ability to perform the promised service dependably and accurately.	When a doctor says she will attend me back in 15 minutes, does she do so? Does the nurse or compounder follow the doctors exact instructions? Is my record sheet free of errors?
Responsiveness: Willingness to help customers and provide prompt service.	When there is a problem with my record sheet, does the hospital resolve the problem quickly? Is my doctor willing to answer my questions? Are charges for medication / hospitalization billed to my account promptly?

Competence: Possession of the required skills and knowledge to perform the service.	Is the hospital back office able to process my transactions without fumbling around? Does my hospital have the research capabilities to accurately track latest developments? When I call front affice executive, is the person at the other end able to answer my questions?
Courtesy: Politeness, respect, consideration, and friendliness of contact personnel.	Does the front office executive have a pleasant demeanor? Does my doctor or nurse refrain from acting busy or being rude when I ask questions? Are the telephone operators in the hospital consistently polite when answering my calls?
Credibility: Trustworthiness, believability, honesty of service provider.	Does the hospital have a good reputation? Does my doctor refrain from influencing me for unnecessary diagnostics? Are the rates/fees charged by my hospital consistent with the services provided?
Security: Freedom from danger, risk, or doubt.	Is it safe for me to use my credit card with the hospital? Does my hospital staff know where my record is? Is my fact sheet safe from unauthorized
Access: Approachability and ease of contact.	How easy is it for me to talk to senior doctors when have a problem? Is it easy to get through to my doctor over the phone? Does the hospital have a 24-hour, toll-free telephone number?

Table 3 Definition of Modified SERVQUAL Dimensions

Dimension	Definition
angibles	Appearance of physical facilities, equipment, personnel, and communication materials
Reliability	Ability to perform the promised service dependably and accurately
Responsiveness	Willingness to help customers and provide prompt service.

Assurance	Knowledge and courtesy of employees and their ability to convey trust and confidence
Empathy	Caring, individualized attention the firm provides its customers

CONCLUSION

An investigation of the disparity that exists between hospital policy, practice, and service levels finds that a number of key reasons are responsible for the inconsistencies that have a considerable influence on the quality of healthcare that is provided. It is necessary to address these gaps in order to improve patient outcomes, ensure consistency in care, and enhance the overall efficiency of the healthcare system. A patient-centered approach, continuous monitoring, resource allocation, and alignment are all things that are brought to light by the findings of this study, which highlight the necessity of these things. It is essential that policies and practices are in line with one another. In order to ensure that all levels of personnel are aware of the hospital's rules, they must be properly established and conveyed to them. Frequently, ambiguities in policy terminology result in a variety of interpretations and actions that are inconsistent with one another. The implementation of ongoing education and training programs is absolutely necessary in order to guarantee that healthcare personnel comprehend and comply with these laws. The adherence to policies can be strengthened through the use of regular workshops and simulations, which can also serve to bridge the gap between policy and practice. An additional essential component is the incorporation of practices that are supported by research into hospital policies. It is important that policies are based on the most recent findings from medical research and studies. Mechanisms that allow hospitals to routinely alter their policies in accordance with new evidence are required. Another key step in the process of refining policies and ensuring that they are applicable and efficient in real-world settings is the establishment of robust feedback systems via which staff members can discuss issues encountered during implementation.

REFERENCES

[1] Cleary, M., Visentin, D. C., West, S., Andrews, S., McLean, L., & Kornhaber, R. (2018). Bringing research to the bedside: Knowledge translation in the mental health care of burns patients. International Journal of Mental Health Nursing, 27(6), 1869–1876.

[2] Cogin, J. A., Ng, J. L., & Lee, I. (2016). Controlling healthcare professionals: How human resource management influences job attitudes and operational efficiency. Human Resources for Health, 14(1), 55.

[3] Corbin, Dwyer, S., & Buckle, J. L. (2019). The space between: On being an insider–outsider in qualitative research. International Journal of Qualitative Methods, 8(1), 54–63.

[4] Creswell, J. W. (2017). Qualitative inquiry and research design: Choosing among five approaches. Thousand Oaks, CA: Sage.

[5] Cruz, E. V., & Higginbottom, G. (2023). The use of focused ethnography in nursing research. Nurse Researcher, 20(4), 36–43.

[6] Cudmore, H., & Sondermyer, J. (2017). Through the looking glass: Being a critical ethnographic researcher in a familiar nursing context. Nurse Researcher, 14(3), 25–35.

[7] Cummings, G. C., Fraser, K., & Tarlier, D. S. (2023). Implementing advanced nurse practitioner roles in acute care: An evaluation of organisational change. Journal of Nursing Administration, 33(3), 139–145.

[8] Davenport, E., & Hall, H. (2022). Organisational knowledge and communities of practice. Annual Review of Information Science and Technology, 36(1), 170–227.
[9] Davidson, A., Ray, M. A., & Turkel, M. C. (2021). Nursing, caring and complexity science for human–environment well-being. New York, NY: Springer.
[10] Davis, G., Wanna, J., Warhurst, J., & Weller, P. (2023). Public policy in Australia. Sydney, NSW: Allen & Unwin.
[11] Foucault, M. (2017). Discipline and punish: The birth of the prison. London: Penguin Books.
[12] Fussell, S. R., & Krauss, R. M. (2020). Accuracy and bias in estimates of others' knowledge. European Journal of Social Psychology, 21(5), 445–454.
[13] Gauthier, S., Melvin, I., Mylopoulous, M., & Abdullah, N. (2018). Resident and attending perceptions during observation in internal medicine: A qualitative study. Medical Education, 52, 1249–1258.
[14] George, J. F., Iacono, S., & Kling, R. (2015). Learning in context: Extensively computerised work groups as communities-of-practice. Accounting, Management and Information Technologies, 5(3), 185–202.
[15] Gleeson, D. H., Legge, D. G., & O'Neill, D. (2019). Evaluating health policy capacity: Learning from international and Australian experience. Australia and New Zealand Health Policy, 6(3), 1–15.