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**Patient service as a component of assessing health care system’s performance – conceptual framework**

**Summary**

**Introduction:** Systematic evidence about suboptimal quality of care in the segment of chronic patients along with widely published incidents of poor practice have made quality a priority issue for policy makers. This increased interest has intensified efforts to develop quality indicators to assess performance at multiple levels of the health care system.

**The purpose:** This paper aims at discussing the relevance of incorporating customer service into the evaluation process of health care system’s performance.

**Research approach:** The paper is based on the literature review. It is mainly conceptual in its form. The authors propose the conceptual framework and identify a new dimension of a customer service in the segment of chronically ill patients.

**Analysis findings:** As a result, a new conceptual framework for the evaluation of the health care system’s performance in the segment of chronic patients has been developed. Continuity of care has been introduced as a new quality item.

**Social implications:** Most OECD countries face aging population. Therefore, the quality of health care becomes a priority more than ever. The research findings can contribute to better understanding of customer service in the segment of chronic patients and be helpful in assessing health system’s performance in Poland.

**Keywords:** health market, patient service, integrated health care, continuity of care, quality measurement

**JEL code:** I11

**Introduction**

Chronically ill patients usually suffer from more than one illness. In such circumstances, patient service in health care systems requires the coordination of care, that could face multimorbidity. Shortcomings in coordination, be it between service providers themselves, or between patients and service providers, are a threat to the continuity of care, therefore also to achieving positive treatment results. Poor coordination of care may lead to providing patients or their family with contradictory information and recommendations, which in turn provokes loss of trust in a service provider (Kautz et al. 2007, s. 286). Therefore, lack of coordination may cause the chronic patient to be disoriented, insufficiently informed and failing to fol-
low doctor’s orders. What is more, in view of the fact that most therapeutic process occurs away from service provider’s facility and it is dependent on patients’ involvement and on patients’ informal care-givers, such a situation creates a risk of patients experiencing anxiety and additional stress. In such circumstances, there is but a step separating us from patients’ dissatisfaction with the process of service received and decreased treatment efficiency and effectiveness resulting from repeated examinations, medical errors, misunderstandings, or their lack of awareness that worrying symptoms of exacerbating disease are emerging, while overall the situation gives rise to higher health care costs.

Therefore, the purpose of this paper is to discuss the relevance of incorporating customer service into the evaluation process of health care system’s performance. The authors propose the conceptual framework and identifies a new dimension of a customer service in the segment of chronically ill patients.

**Patient service defined**

Starting from the macro perspective, the question that inevitably must be posed regards the evaluation of health care system operation. Furthermore, adopting the perspective of a chronically ill patient as a major beneficiary of health care integration, the core of this discussion is patient service understood as a comprehensive process of fulfilling the patient’s needs.

In a wider perspective, patient service is a set/comparison of activities performed by a services provider (a network of service providers), aimed at the improvement of service quality. Customer (here: chronic patient) service perceived in this fashion becomes a means to an end, based on a series of activities, during which a provider interacts with patients. Such understanding of customer service is strongly exhibited in marketing literature, in particular in the works of V.A. Zaithaml (2000, p. 67-85), E.K. Harris (2003), or H. Verma (2001, p. 69-78). The representatives of the Nordic school of relationship marketing perceive patient service in a similar manner, treating it as relations established between patients and providers, both during actual service encounters, as well as during symbolic interactions (Grönroos 2000, p. 80-81; Gummesson 2004, p. 20-21; Storbacka et al. 1994). The latter ones are carried out for the sake of image development and they arise from customer’s encounters with the identity of an organization (Rudawska 2011, p. 402-411). Such a view of patient service has an organizational dimension, which in terms of integrated health care should be linked with a chain of relations between a chronic patient and a network of providers, and not with service-related episodes occurring at the level of a single medical facility. In this perspective, patient service assumes a holistic dimension, perceived as the entirety of relations established with a chronic patient by the network of medical institutions providing services to such a patient, which translates into a generalized perception of health care system operation. Therefore, a chain of micro-relations between patients and service providers contributes to the macro-relation between patients and the health care system. It is this
The desire to conduct international comparisons of health care systems operation leads one to seek such indicators of the above-accentuated macro-relations that could serve as a basis for a holistic evaluation and performance measurement. Previous experiences show that the most commonly applied evaluation criteria include: commitment of financial resources allocated to health care (expenditure) as well as indicators of population’s health condition, such as mortality rate. Limiting comparative analyses of health care systems to these two dimensions gives rise to justified controversies in literature. Since they appear to be just elements of the evaluation of a given country’s achievements as a whole, and not components of evaluation of health care systems, which leaves the unanswered question of the value generated by the funds invested in the health of society. A series of committees and organizations involved in health issues and its protection try to fill that gap, to name but a few: OECD, WHO, ECDC, AHRQ and the European Commission. The effect of their involvement takes the form of numerous projects promoting quality improvement, patient’s safety as well as infection prevention and control. 27 international projects dedicated to these issues were developed only within the span of the last thirty years (1985-2011). They are all comprehensively presented by Baylina and Moreira (2011, p. 258-261). All of the projects illustrate the scale of interest in the improvement of health care systems operation. Some projects focus on selected levels of health care, like hospitals in the projects such as: COMAC/HRS/QA of the European Commission, PATH of the World Health Organization, on specific areas of care, like patient’s safety in the projects such as: SIMPATIE of the European Commission, WHO’s Second Patient Safety Challenge, or on infections of institutional origin (like hospital-acquired infections) in projects such as: PILGRIM of the European Commission, HAI-Net created by the ECDC. Other projects are of more comprehensive nature, which means that their priority is a holistic evaluation of health care system operation, which enables international comparisons. Health Care Quality Indicators – HCQI, a proposal initiated by the OECD in 2002 is an example of such projects.

In this way, the authors refer to a global perspective of the OECD’s evaluation of health care systems operation (Health Care Quality Indicators project), treating it as a classic, traditional vision, therefore - in the authors’ interpretation – recognizing the health care system as a whole comprised of individual parts. The vision refers to aims set to systems, which are typically derived from the objectives of health policy of a given country. The key elements commonly include – irrespectively of the existing model of the system – health care quality, access to care and care-related costs e.g. level of expenditure allocated to health care (Arah, Westert, et al. 2006, p. 6). The OECD’s concept model corresponds to the proposal of the American Institute of Medicine, defining four functions of a health care system: (1) maintaining the health of an individual, (2) improving the health of an individual, (3)
Figure 1
Conceptual framework for the OECD Health Care Quality Indicators Project

ensuring that patients are able to function with their disease or disability, once it occurs, and (4) providing care to patients at the last stage of their life (terminal care) (OECD 2010, p. 37).

The OECD’s proposal shows a health care system in a wider perspective of health determinants unrelated to health care systems, such as lifestyle (Figure 1).

In the figure above, quality, next to access and costs, is treated as a fundamental component of system evaluation, while at the same time it is assumed that quality is to be evaluated through the prism of care efficiency, patient’s safety and the system’s ability to react to patient’s needs. A health care system is assessed in terms of the three above-listed dimensions individually.

**Introducing relational perspective into the health care system’s performance**

According to the authors, the introduction of an additional dimension is required in order to account for the specificity of integrated health care in chronic diseases. Adopting the perception of a chronically ill patient, being the main beneficiary of integrated health care, one may assume that from a customer’s perspective ensuring continuity of care is a fundamental criterion of evaluating the efficiency of a system operating in this way (Antunes, Moreira 2011, p. 130). Continuity of care is a dimension involving a holistic, comprehensive approach to patient care. It requires to set the role of a institutional coordinator, that will ensure the care coordination for defined population of patients. Coordination in that sense can be measured by the existence of the skill mix of primary care providers, the collaboration within primary care and with secondary care providers, and the integration of certain public health functions (Kringos et al., 2013, p. 689). Therefore, patient care and its attribute in the form of continuity becomes an element of evaluating thus operating system. Patient care is understood not merely as a singular episode occurring in the course of health care service delivery, but as a series of episodes building up to a service encounter, which is a “path” in the system of usually a chronically ill patient. Furthermore, a service encounter, being a sequence of coordinated episodes in integrated health care, occurs at two planes: a technical one (treatment in the strict sense – *cure*) and a functional one (care over patient – *care*) (Krot, Rudawska 2010, p. 126). Thus, interactions occurring during a service encounter regard not only direct, personal contacts between the treated party and the treating party, but also patient’s interaction with the physical environment of a service provider and its material certificate. With such a wide interpretation of a service encounter, interactions go beyond interpersonal character and they also encompass such elements of patient care that involve the material potential of a network of cooperating providers (from the natural environment to technical equipment and pharmaceuticals).

Therefore, patient care in integrated health care goes beyond a traditionally understood set of activities performed for the patient and it comprises the establishment of a relation with other participants of exchange (organizations cooperating in the network and their rep-
resentatives) in order to establish a long-term and mutually satisfactory cooperation. Such an interpretation is close to a marketing interpretation of customer service, found in the works of A. Payne (1996, p. 218). Integration of delivery chain may also stimulate partnership building in the local communities. The formation of partnership may include a shared electronic health record system, providing disease registers, multidisciplinary care plans and a patient recall system (Reeve et al., 2015a, p. 414). Partnership may also involve members of patients’ families, that stresses the importance of families and their guardianship roles (Reeve et al., 2015b, p. 485). Overall, this approach may ensure much safer and efficient patient care for population. The philosophical change behind the idea of care integration can therefore be described as moving from an acute hospital-based care service to pro-actively delivering appropriate care to residents in their communities (Reeve et al., 2015a, p. 414).

Adoption of the relational perspective of a service encounter, corresponding – in the authors’ view – to the specificity of integrated health care, in which a personal relation is one, but not the only link, sheds new light on the question of patient care. Hence, it goes beyond its traditional understanding, brought down to interpersonal interaction of purely medical nature, aimed at concluding a transaction. This approach has been initiated by Solomon et al. (1985, p. 99-111). According to the relational approach, patient care becomes a series of episodes realized by a network of cooperating service providers (on the basis of selective contracts), which create a relation of a chronically ill patient with integrated care providers, while the latter ones are understood as a network of organizations, and not merely as its representative in the form of a medical professional. The trend is strongly emphasized in the work of K. Storbacka et al. (1994, p. 21-38). This perspective is also closer to a procedural approach, in which a service is perceived as a continuum, and not as a series of contacts oriented at a final transaction. Patient care in this work is therefore understood as a process commencing with needs diagnosis, followed by the provision of comprehensive, coordinated offer of health services, concluded with a control of the results obtained. Such an interpretation of patient care encompasses all the interactions between the patient and a network of service providers prior to, in the course of and after the decision-making regarding treatment.

Patient service in integrated care

Patient care in integrated health care can be divided into three stages: preliminary stage, stage of service consumption and final stage (Lehtinen, Lehtinen 1991, p. 287-303). In the environment of integrated health care the first stage is related to organizational and technical preparation of case management program/plan and it includes patient’s meeting with a case manager and possibly an insurer as well as remote planning of patient’s path (with the use of electronic communication channels, such as the Internet, telephone, or fax). Particular elements of the stage comprise, for instance: movement along designated traffic routes, parking, registration, waiting for a meeting, obtaining information – Fig. 2.
The second stage regards the consumption of a set of health services and it requires intensive interactions between the patient and medical personnel as well as the facilities of the network of service providers. In a hypothetical example of treating diabetes, this stage will include diagnostic and laboratory tests, consultations with primary care physician, consultations with specialists (ophthalmologist, nephrologist, diabetologist), recommendations of a dietician, rehabilitation services. The stage of consuming a set of integrated services corresponds to a sequence of particular activities that ought to be carried out each day for a sick individual, along with the determination of the scope of responsibility of individual medical professionals that formulate a team caring for such a patient (Kowalska 2009, p. 33). This stage extends over time, adequately to the type of the patient’s chronic illness and the time during which the case management program applies.

The service process is concluded by a final stage, which comprises elements related to payment (if required), control of treatment progress and recommendations for further medical consultations at a different level of care, referral to rehabilitation and possibly designating the next date of a follow-up visit (Fig. 2). Each of the three stages entails a series of additional elements in the form of auxiliary and complementary services (Grönroos 1994, p. 8; Orava, Tuominen 2002, p. 680).

Integrated health care service can therefore be defined as providing the chronic patient with health care, which aims to directly, or indirectly affect patient’s health through proce-

Figure 2
Stages of patient service in the integrated health care

Source: own work.
dures performed by medical personnel. However, a health service is in fact not just a chain of a series of strictly medical activities, such as diagnosis, consultation, preparation to surgery, an operation, post-operative care, but it is also a comprehensive process of patient care aimed at satisfying the patient’s health-related and health-unrelated needs (such as the sense of safety, empathy, psychological comfort). Once more it needs to be emphasized that continuity is the fundamental attribute of such care, encompassing the dimensions of health care quality proposed by the OECD and the American Institute of Medicine, becoming a fundamental indicator of the quality of the process of patient care (Fig. 3).

**Figure 3**

**Patient service – relational approach**

![Diagram](image)

Source: own work.

**Conclusions**

Both perspectives outlined above are indispensable to comprehensively evaluate the process of patient care in integrated health care. The study of patient’s perception allows presenting the issue from the point of view of service beneficiary, which corresponds to the idea of client-oriented care. Analysis of the internal process ensuring the integration of patient care in turn permits to include organizational components in the evaluation of patient care, both those invisible to patients, but still experienced by them, as well as the elements which constitute components of the image of a cooperating network of service providers.

**Bibliography**


Obsługa pacjenta jako składowa oceny funkcjonowania systemu ochrony zdrowia – zarys koncepcji

Streszczenie

Wprowadzenie: systematyczne dowody naukowe dotyczące braku optymalnej jakości opieki w segmencie pacjentów przewlekłych choroby wraz z szeroko publikowanymi przypadkami złych praktyk sprawiły, że jakość stała się kwestią priorytetową dla decydentów. To zwiększone zainteresowanie zintensyfikowało wysiłki w celu opracowania wskaźników jakości do oceny działania systemu ochrony zdrowia na wielu jego poziomach.

Cel: celem artykułu jest dyskusja na temat włączenia obsługi pacjenta jako elementu oceny funkcjonowania systemu ochrony zdrowia.


Analiza wyników: na podstawie analiz zarysowano nową koncepcję oceny funkcjonowania systemu ochrony zdrowia, w odniesieniu do segmentu pacjentów chorych przewlekłych. Wprowadzono ciągłość opieki jako nowy atrybut jakości.

Implikacje społeczne: większość krajów OECD boryka się ze zjawiskiem starających się społeczeństw. W tej perspektywie jakość opieki staje się priorytetem. Uzyskane wyniki badań mogą się przyczynić do lepszego zrozumienia procesu obsługi pacjentów przewlekłych chorych oraz być pomocne przy ocenie funkcjonowania systemu ochrony zdrowia w Polsce.

Słowa kluczowe: rynek zdrowia, obsługa pacjenta, zintegrowana opieka zdrowotna, ciągłość opieki, zarządzanie jakością.

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Obслугивание пациента как составная часть оценки функционирования системы здравоохранения – зарисовка концепции

Резюме

Введение: систематические научные доказательства, касающиеся отсутствия оптимального качества опеки в сегменте пациентов с хроническими заболеваниями, наряду с широко публикуемыми случаями плохих практик, привели к тому, что качество стало приоритетным вопросом для принимающих решений. Этот повышенный интерес интенсифицировал усилия для разработки показателей качества системы здравоохранения на многих ее уровнях.

Цель: цель статьи – дискуссия по теме включения обслуживания пациента в качестве элемента оценки функционирования системы здравоохранения.

Исследовательский подход: статья основана на обзоре литературы. Ее формула – в основном концептуальная. Авторы предлагают зарисовку заглав-
ной концепции и выявляют новое измерение обслуживания пациента в сегменте хронически больных.

**Анализ результатов:** на основе анализа зарисовали новую концепцию оценки функционирования системы здравоохранения по отношению к сегменту пациентов с хроническими заболеваниями. Ввели непрерывность опеки в качестве нового атрибута качества.

**Социальные импликации:** большинство стран-членов ОЭСР сталкивается с явлением стареющих обществ. В этой перспективе качество опеки становится приоритетом. Полученные результаты исследований могут способствовать лучшему пониманию процесса обслуживания хронически больных и помочь при оценке функционирования системы здравоохранения в Польше.

**Ключевые слова:** рынок здоровья, обслуживание пациента, интегрированная здравоохранительная опека, непрерывность опеки, управление качеством.

**Коды JEL:** I11

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