CHAPTER – II

REVIEW OF LITERATURE
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CHAPTER – II

REVIEW OF LITERATURE

This chapter provides an elaborate national and international literature pertaining to facilities oriented strategies, CRM strategies, Promotion strategy, cost strategy, need based strategies, patient convenience strategies and patient satisfaction towards medical service quality strategies. The relevant segmentation, targeting the patients and service quality literature are analyzed in more depth and elucidates the important issues that remain unanswered.

2.1 SERVICE QUALITY STRATEGIES

The service quality dimension provides more focus towards various strategies employee by the service providers to maximize their customers and to offer them satisfaction. The service quality dimension actually designed to ascertain the various service quality strategies.

Parasuraman, Zeithaml and Berry (1990) were a slight modification of Gonzalez Padin and Romon. (2005) model and explains that the expected service is influenced by the word-of-mouth, the personal needs, past experience and also by the external communication to customers. A perception gap can appear between the expected service and the perceived service.

Glied, (2000) indicated that the expectations of the customer depend on the five determinants market communication, image, word of mouth, customer needs and customer learning. Experiences depend on the technical quality (what/ outcome) and the functional quality (how/process), which is filtered.
through the image (who). Both expectations and experiences can create a perception gap.

Argote, (2000) explains that highly skilled physicians, nurses, administrators, and ancillary staff are critical to producing high-quality outcomes and effective quality improvement hence hospital growth.

Argote and Ingram, (2000) suggests that the key to service delivery is to adapt to circumstances that are constantly changing and that the long-term winners are the best adapters, but are not necessarily the winners of today’s race for market share. Highly skilled physicians, nurses, administrators, and ancillary staff are critical to producing high-quality outcomes and effective quality improvement hence hospital growth.

Cohen and Levinthal (2001) found that in order to facilitate service quality and growth, hospitals must implement effective human resource strategies involving selective hiring, and retention of physicians and nurses.

MacAuley, (2001) in his descriptive approach found that the company and customer perspectives on productivity, when considered separately, are at odds with each other; improvement in one type of productivity is invariably accompanied by deterioration in the other. But the two perspectives need not and should not be viewed independently. Enlightened companies that examine productivity from a dual company-customer perspective can benefit from synergies that elude service businesses focusing on a single perspective.

Parasuraman (2002) identified that the conventional view of productivity is that it represents some measure of the ratio of a produce’s
output to input. Such a producer-oriented perspective works well in the context of products ranging from potato chips to computer chips, cosmetics to chemicals, mobile telephones to mining equipment. The output in product contexts can be measured relatively easily and unambiguously in terms of units produced in a manufacturing facility and hence, improving productivity in product contexts is a matter of either: increasing the units produced that is output with no increase or less than a proportionate increase in production costs (input); or decreasing production costs with no decrease or less than a proportionate decrease in units produced. In service contexts customers often play a co-production role, providing some amount of direct or indirect input in the form of time, physical effort and mental energy. When service businesses subscribe to a purely producer-oriented view of productivity which is the case more often than not – the quality of service to customers invariably suffers.

Brown and Duguid, (2003) in their research found that there is need for selective hiring of qualified staff. Successful recruitment and retention of staff is tied to empowerment of staff that must be treated as full partners in the hospital operation and given opportunities for advancement. The hospitals need to place great emphasis on recruiting and retaining top-level physicians and nurses, accompanied by an effort to encourage these professionals to form working teams, including case managers, pharmacists, social workers and others, to promote quality

Coulthard, (2004) identified ten determinants of service quality that may relate to any service: Competence, Courtesy, Credibility; Security; Access; Communication, Understanding knowing the customer; Tangibles;
Reliability; Responsiveness. Later they were reduced to five to include Tangibles; Reliability; Responsiveness; Assurance: competence, courtesy, trustworthiness, security and Empathy.

**Crewson, (2004)** monitoring of doctors on staff (or with privileges) and ensuring that they must continue to meet certain performance and practice standards to retain credentials. To improve efficiency in service delivery, public sector hospitals must build the capacity to attract and employ an adequate number of high-quality nurses.

**Lui, (2005)** Considered, for instance, a cable-television company’s call center offering telephone-based support to customers. The call center’s productivity measured in conventional terms converts to a metric such as the number of customer calls processed per hour per employee. Trying to maximize this metric is a matter of depleting the call center staff and/or setting stringent performance standards for the staff; average time per call not to exceed two minutes; number of calls processed per hour should be at least 30). The problem with this approach to boosting productivity is its failure to consider customers inputs into the process (e.g. waiting time and emotional energy due to frustration), as well as the outputs experienced by the customers for example service performance, satisfaction. So far, the service quality dimensions at national and international level emphasized the service quality strategies of service providers. In particular, the perception of customers is transformed into productivity of the service provider by rendering good quality of service and satisfaction.
2.2 FACILITIES ORIENTED STRATEGIES

Providing facilities to the patients and other service seekers is a preliminary aspect to maintain the service quality of any service sector. In health care industry it is more concerned to the patients to express their opinion on service quality of the medical services and hospitals. The following reviews are done systematically to underpin the importance of facilities oriented strategies.

Douglas M. Stewart (2011) addresses the issue of service design, specifically that of designing the service encounter for improved quality. Based on the 3 Ts of task, treatment and tangibles as a means of organizing the application of the diverse and growing body of service quality literature to encounter design. The framework is consistent with how successful service managers disaggregate the design problem. More importantly, we show that mutually supportive interrelationships between the 3 Ts produce an opportunity for designing in robustness to service failure. The framework supported the case based evidence.

Levitt (1972) explains that there is a long history of design-focused research and service operations. These papers are focused on many different objectives from that of generating greater efficiency to attaining better alignment with the needs of the customers. The production line approach towards better service quality.
Wycoff (1984). Explains “Quality is the degree of excellence intended, and control of variability in achieving that excellence, in meeting the customer's requirements.”

Klauss (1985) addressed the need for moving beyond a purely product or process focus to incorporate the impact of the transient interpersonal nature of the service encounter on service quality.

Schlesinger and Heskett (1991) developed a system dynamics model to explain the feedback relationships between organizational variables that cause poor service culture and result in service failures. The system dynamics model indicates that poor culture is the result of two positive feedback loops, meaning that it will get worse at an increasing rate.

Collier (1994) uses LISREL to develop his service/quality process maps. The maps are a series of causal relationships between design variables (in the form of process performance measures) and perceptual variables (such as customer satisfaction). The relationships are either direct, or through some intermediary variables. The validity and strengths on any anticipated relationships can be empirically derived from company data, and then used to guide quality improvement.

Armstrong (1995) investigated linking customers’ perception of service quality with service system design variables through linear models, neural nets, and multivariate adaptive regression splines. In addition to demonstrating the usefulness of linking design to perceptions, the author found that simple linear models provided better fit than the more advanced techniques.
Hartline, Maxham and McKee (2000) discuss how a customer-oriented strategy from senior management can be disseminated to the front-line employees through specific control mechanisms.

The review clearly expresses the link between customers' perception on facility-oriented strategies and service quality. It also elucidates the nature of facilities which has the intimate connection with the service quality of medical services.

2.3 CRM AND SERVICE QUALITY STRATEGIES

The patient relationship management and service quality of medical services is a vital issue in the competitive environment. In this section, the researcher thoroughly analyses the various outputs of service quality focusing towards relationship management between service providers and service seekers.


Cohen and Levinthal (2001) in their research explained that to facilitate service quality and growth, hospitals must implement effective human resource strategies involving selective hiring, and retention of physicians and nurses; monitoring of doctors on staff (or with privileges) and ensuring that they must continue to meet certain performance and practice standards to retain credentials.
**Allen, (2001)** Addresses that technology for harnessing of Information and data play a critical role in the quality service delivery in hospitals Investments. The quality and timing of information should be tailored to the needs of decision makers. Information should not just include current and historic data, but also include projections for the future.

**Karimi, Somers, Gupta, (2001)** Addresses that the main ingredients of a real-time system involve its timeliness. Hospitals want to develop a system that allows all caregivers to have access to relevant information as soon as it is available. To that end, the hospitals have or are adopting applications that do the following: Reduce time lags in getting laboratory and imaging results.

**Blas and Limbambala (2001)** explains that a proprietary information systems that shapes the culture, patient mix, and staffing of the hospital and engaging physicians and nurses in developing or adapting Information Technology serves to ensure that the resulting system meets the needs of clinicians.

**Nerenz and Neil, (2001)** recommends the kinds of quality-related Information Technology investments that the hospitals need to make include: Moving to a paperless system that provides information at the right time (electronic medical records, e-hospital notes with input at bedside); Moving toward bar-coded medications and automatic dispensing; Coordinating patient admissions with bed capacity, immediate tracking of filled beds and daily changes in nursing needs.
MacAuley (2001) Recommends that the private hospitals need to develop a system that allows all caregivers to have access to relevant information as soon as it is available.

Oliveira-Cruz, Hanson and Mills (2001) In their research informs that the hospitals have to adopt applications that do the following: reduce time lags in getting laboratory and imaging results; deliver information on test results, history, health status.

Dutton and Starbuck (2002) in his research paper explains the importance of technology explains that technology to facilitate service assessment and improvement process is essential.

Cibulskis and Hiawallyer (2002) found that the hospital must show four main commitments: a willingness to invest in Information Technology; investments in Information Technology and in Quality Insurance departments with qualified staff that abstract medical records, analyze data, and facilitate the Quality Insurance process.

Davis, Hughes and Audet, (2002) The newer Information Technology systems reflect the hospitals commitment and willingness to invest in the tools that promote quality.

Baldrige National Quality Program, (2003) found in his research that by encouraging buy-in, and helps create Information Technology champions among the staff, who then teach and encourage their colleagues to use the new system.

Singh and Ranchod, (2004) in his research explains that service quality provided to the medical service seekers is not a one-time process, but one that must engage clinicians and administrators to adapt and refine systems over time.

Sun and Shibo, (2005) found that technology must be customized to incorporate and meet the particular needs and circumstances of the hospital.

Tam, (2005) explains that the medical service providers treating patients are requested to treat the medical service seekers based on the latest information; and making user-friendly guidelines and recommendations readily accessible to physicians, based on the latest medical research on specific conditions, procedures, medications,

The reviews clearly present the current scenario of patient relationship management. It also underpins the nature of relationship among patients, nurses, doctors and other employees of hospitals. It also traced how the relationship management is related to patient satisfaction.

2.4 PROMOTION STRATEGIES

The promotional strategies of medical services create awareness among the patients to have good health and to practice health and hygiene in their day to day life. These strategies also give transparent information pertaining to
facilities offered, caring system and cost of the treatment. The following reviews explain the promotional strategies of medical services to attract the patients.

Dwyer et al., 1987, Like all marketing relationships, patient-physician relationships evolve; they develop gradually and progress through stages of awareness, exploration, expansion, commitment, and dissolution

Gronroos, Christian (1988) concluded that as a wider choice of physicians should produce increased trust in ones’ current physician, the following hypothesis is posited:

Holmes ad Rempel, 1989, Patient-physician relationships usually begin with history taking and diagnosis followed by treatment and follow-up visits. As they progress through these stages, patient’s belief about the behaviors of trusted physicians grow more structured and congruent with expectations.

Carman, 1990 the current care structure limits patients’ choice of physicians and plans. In most cases, employees must visit physicians who work under employer purchased plans such arrangements lower trust because given free choice of physicians, patients will change physicians when trust breaks down. If this safety valve is restricted, trust between physicians and patients are likely to erode.

Hawkins. Best and Coney. 1992 analyzed that the hospital physician can select for an external information search from a variety of information sources, that can roughly be divided into professional sources and commercial
For both categories it is possible to make a distinction between personal, printed, or computer-based drug information sources.

**Babakus and Boiler, 1992** argued that this authorization process may degrade treatment and symbolically challenge competence of physicians. Because patients’ trust depends on believing that their physician can act in their best interest, patients awareness of utilization reviews by insurers may lower their trust in their physician This possibility is reflected in the hypothesis of factors influencing service quality of medical services.

**Morgan and Hunt, 1994,** proved the awareness of these incentives could undermine patients’ beliefs that their physician is acting in their best interest and consequently could lower trust.

**Caldwell, 1997** observes the physicians who comply with insurers’ care advice commonly receive bonus payments; non – complying physicians may find their contracts with managed care companies canceled

**Mechanic and Schlesinger, 1996; O’ Malley, 1997** argues that these plans threaten patients’ trust in their physician. Patients may believe that incentives for opportunistic behavior will entice their physician to put his or her self-interest above their interests. “When a party believes that a partner engages in opportunistic behavior, such perceptions will lead to decreased trust”

**Brink and Shuts, 1997** found in his research that cost containment measure is the utilization review, which precludes treatments unauthorized by insurers.
Peyser, 1997, analysed in his research works that physicians’ need to increase their patients’ trust grows. Although patients’ satisfaction and trust are higher in fee-for-service systems than in more restrictive systems like HMOs.

Mummalaneni and Gopalakrishna, 1997, explains that health care service quality alone cannot suggest ways to promote patients’ trust in their physician. Modeling the antecedents and consequences of such trust is a precursor to prescribing such ways; hence, our goal for this study.

The reviews proved that promotional strategies of hospitals at national and international levels need to be revisited actually identify the patients expectation. The present research focuses the promotional strategies of medical services in this right direction.

2.5 COST STRATEGY

Cost of the service is an important aspect in service quality dimension. The cost is a deciding factor and also considered as very important in the patients view point. The following reviews highlight the importance of cost in estimating the quality of service.

Purola 1971, Purola1972 in their research on the utilization of health care services is of increasing value because of the high and still rising expenditure in health care. Such research is associated with the medical, social and behavioral sciences and also with health economics
Brink and Shute, 1997; Mechanic and Schlesinger, 1996 explains the withheld income and capitation (i.e., fixed annual fee for treating a patient), these plans encourage physicians to minimize treatment costs.

Anderson EA, Zwelling LA (2004) In an innovative study explained service cost management had become one of the most important and most debated topics within the service sector. This is especially true for health care, as the controversy rages on how the existing American system should be restructured. Health care reform aimed at reducing costs and ensuring access to all Americans cannot be allowed to jeopardize the quality of care. The main purpose of this report is to establish a framework by which to approach the issue of quality measurement, delineate the various cost of service quality that exist in health care, and explore how these elements affect one another. We propose that the issue of quality measurement in health care be approached as an integration of service quality attributes common to other service organizations and technical quality attributes unique to health care.

The World Bank and TNHSP (2005) In 2005, the World Bank approved the Tamil Nadu Health Systems Project for a total cost of Rs. 597.15 crores. The World Bank’s involvement in the project has been extremely advantageous. It has helped in introducing new approaches in the way the health sector functions in the State. While the health system in Tamil Nadu has been fairly effective in providing basic health needs to its people, it is expected that the goals sought in the project will demonstrate the impact of cutting-edge reforms.
**Priya Deshpande (2005)** explains in her journal *Service Quality Perspectives and Satisfaction in Health Care Systems – A study of select hospitals in Hyderabad.*

Liberalization, Privatization and Globalization (LPG) has brought unprecedented changes in the economic, trade and industrial scenario. LPG environment has exposed various organizations including the services sectors to the challenges of competition; service quality, cost and the competitive environment will help organization to modernize. The impact globalization and its implications for our country’s health conclaves. With the state – of – the art medical procedure, equipment and facilities now available in India, patients from developed countries like Canada and Britain are choosing Indian Hospitals. Today India is not only well poised to meet the health care challenges of the millennium but also equipped with the talent and strength to contribute in further developing the health and economy of the world.”

Health is wealth”. The old saying still holds true. It is increasingly being recognized that good health is an important contributor to the productivity and economic growth at the same time it is first and foremost and an end itself. Perhaps, health care industry is one industry, which never faces a recession. Entry of private participants in the health insurance will enhance the accessibility of health care facilities to millions thus providing the right kind of health care services at affordable cost.

**Program Advisor, EC Supported H&FW Sector Investment Program in India, New Delhi (2008)** With the present state of economic health of State Governments and the increasing deficit in national budgets, it is
unlikely that public sector allocations spending on healthcare would register any increase. Most multi bilateral donor organizations (except for the World Bank) do not wish to invest in secondary or tertiary medical care services provided by the government in India.

The review concludes that the standardization argument that predominates in the national and international literature do not focus more on service quality strategies in the dimensions facilities oriented strategies, CRM strategies, Promotion strategy, cost strategy, need based strategies and patient convenience strategies. These factors are likely to influence the medical service quality and characteristics significantly. A shortcoming of all six schools of thoughts is that none of them acknowledge these effects that are likely to result more satisfaction to the patients.

2.6 NEED BASED STRATEGIES

The patient needs are to be fulfilled by all the medical services that offer good quality of service. In the perception of service seekers the need and importance given to the patient and the disease is a crucial factor to determine the service quality at the point of inception up to the point of satisfaction.

Adams and Colebourne, (1999) explains that the financial management, in service organizations, has been a constraint and an obstacle to other functions that contribute to service delivery.

Arhin-Tenkorang (2000) suggests an enlightened approach to finance in service organizations. This consists of more participative and positive approach where far from being an obstacle, it contributes to strategic planning,
costing systems, personnel motivation, quality control, continued solvency, and keeping outsider’s confidence in management.

**Peters, Elmendorf, Kandola and Chellaraj, (2000)** explained that political and bureaucratic leakage, fraud, abuse and corrupt practices are likely to occur at every stage of the process as a result of poorly managed expenditure systems, lack of effective auditing and supervision, organizational deficiencies and lax fiscal controls over the flow of public funds.

**Lancaster et al. (2000)** discussed the factors effecting health care reform in the US; these factors are similar to those identified above. Successive UK governments have tried to improve the effectiveness and efficiency of the National Health Service (NHS) with differing degrees of success. One of the most radical changes was implemented in 1991 when the method of funding the service was radically changed. Although still publicly owned and managed, the NHS has been marketed (but not privatized) and business-like principles have been widely introduced. This was achieved by introducing a purchaser/provider split to create an internal or quasi-, market mechanism, albeit artificial.

**Blas and Limbambala (2001)** explained that the Governments in order to provide better services to the medical service seekers had allocated resources for health flow through various layers of national and local government’s institutions on their way to the health facilities.

**Oliveira-Cruz, Hanson, and Mills. (2001)** found that the financial accountability using monitoring, auditing and accounting mechanisms defined
by the country legal and institutional framework is a prerequisite to ensure that allocated funds are used for the intended purposes.

RoK (2001) informs in his research papers that public hospitals in Kenya are in dire need of funding to rehabilitate, redesign, equip and staff them to ensure effective and efficient service delivery to Kenyans.

The National Health Policy 2002 states since 1983 the country has been seeing increase in mortality through ‘life-style’ diseases- diabetes, cancer and cardiovascular disease. The increase in the life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem”. There are little or no resources with the government to invest in facilities to take care of the increasing burden of these emerging diseases. It is estimated that in the next ten years the cost of caring for diabetic patients alone would cripple our economy.

Smee, (2002) addressed that in many developing countries, governments do not have the financial and technical capacity to effectively exercise such oversight and control functions, track and report on allocation, disbursement and use of financial resources.

Sun and Shibo (2005) explained that, there is a need to distinguish “good costs that improves organizational capabilities and quality service delivery from “bad costs that increase bureaucracy hence becoming obstacles to service delivery.
In medical service industry, the convenience of the patients rules and
dominates the entire quality of service offered to the patients. Since, it is the
concern of patient’s life; the service providers take maximum care on patient
convenience. The following reviews highlight the importance of patient
convenient strategies in determining the service quality strategies of hospitals.

Arhin, (2000) in his research papers proved that there is compelling
evidence that communication challenges have an adverse effect on initial
access to health services. These challenges are not limited to encounters with
physicians and hospital care. Patients face significant barriers to health
promotion and disease prevention programs: there is also evidence that they
face significant barriers to first contact with a variety of providers.

Pickton and Broderick, (2001) addresses that the component of service
is valued highly as reflected in the in-depth interviews and influences patient
satisfaction levels significantly.

Brown and Duguid (2003) The researcher indicates that there is a
general pattern of lower use of many preventive and screening programs by
those facing language barriers. Higher use has been reported for some
emergency department services, and for additional tests ordered to compensate
for inadequate communication.

Irving and Dickson, (2004) explains that there is evidence that
communication challenges may result in increased use of expensive diagnostic
tests, increased use of emergency services and decreased use of primary care services, and poor or no patient follow-up when such follow-up is indicated.

**Friedman and Kelman, (2006)** explains that the Communication is the most important aspect of the Service delivery. Since Communication with patients is vital in delivering service satisfaction because when hospital staff takes the time to answer questions of concern to patients, it can alleviate many feelings of uncertainty (EFP, 2006). In addition, when the medical tests and the nature of the treatment are clearly explained, it can alleviate their sense of vulnerability.

**Payne, (2006)** indicates that communication challenges have a negative impact on: access to treatment, participation in preventive measures, ability to obtain consent, ability for health professionals to meet their ethical obligations, quality of care, including, hospital admissions, diagnostic testing, medical errors, patient follow-up, quality of mental health care and patient safety. According to the Institute of Medicine of the National Academies (U.S.), communication challenges contribute to reduced quality, adverse health outcomes, and health disparities.

### 2.8 PATIENT SATISFACTION

SERVQUAL model and its ultimatum end at satisfaction of customers or patients. This section completely enumerates the relationship between service quality and patient satisfaction.

**Parasuraman, et al (1988)** suggested a widely used model known as SERVQUAL for evaluating the superiority of the service quality. In the
SERVQUAL model, Parasuraman ET. Al. identified the gap between the perception and expectation of consumers on the basis of five attributes viz. reliability, responsiveness, assurance, empathy and tangibles to measure consumer satisfaction in the light of service quality (Parasuraman A., Berry L, 1988).

M.G. Zifko-Baliga and F. Robert Krampf (1996) found in his research works that communication includes the transfer of information between a provider and a customer, the degree of interaction and the level of two-way communication. Patients want to know that communication is occurring between different parties involved. The interactive communication such as physician-patient, communication with family members and communication between doctors are been identified as important

S.E. Beatty, Morris Mayer, J.E. Coleman, K.E. Ellis, and J. Lee (1996) observed that relationship refers to the closeness and strength of relationship developed between the provider and a customer.

Mary Draper and Hill Sophie (1996) explains that their purpose of the present paper is to develop a conceptual framework for measuring hospital service quality, expending the existing models and literature on healthcare services to benefit academicians, practitioners and researchers to enhance the understanding of patient perceived hospital service quality addressing this gap in literature as there are a few reliable and valid instruments available; and many service providers are implementing measures that are not aligned to the complexities of the health care setting.
Chahal (2000), in his tri-component model, pointed out that the loyalty of patients towards particular provider of medical service can be measured on the basis of three dimensions viz. using providers again for the same treatment (UPAS), using providers again for different treatments (UPAD) and referring providers to others (RPO). In the tri-component model, Chahal proved that all the above-mentioned loyalty measures depend on the overall service quality. He explained service quality of medical care with three latent constructs. These are physicians’ performance, nursing performance and operational quality.

Andaleeb (2000) found in his research that the quality of healthcare service in rural India have segregated into five dimensions namely, responsiveness, assurance, communication, discipline, and ‘bribe money’ paid to health staff in a study conducted in Bangladesh.

The World Health Report,( 2000) suggests that improvement in the quality of primary healthcare services apart from increasing accessibility and affordability has become a matter of grave concern for the developing nations in the recent years. However, the meaning of quality in healthcare system has been interpreted differently by different researchers.

P.C. Lim, and N.K.H. Tang, (2000) despite considerable work undertaken in the area of measuring service quality in healthcare, there is no consensus yet as to which one of the measurement scales is robust enough for measuring and comparing service quality. In the face of uncertainties, healthcare organizations have to be reprogrammed and renewed, repositioning themselves for the future.
**Balazs and Sports (2000)** stress the importance of health care research in such a context that any insights into how health care delivery can be delivered efficiently and effectively have wide reaching implications. Thus, research into service delivery is extremely important and marketing can be seen to make an important contribution to research in this area.

**Zeithaml, V.A., Berry L.L and Parasuraman A (2000)** explained that the service providers, as a matter of fact, take the satisfaction of customers into account as a main goal of the strategies of their firms.

**Institute of Medicine (2001)** informs that the quality in healthcare is, “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

**Brady and Cronin (2001)** suggested a hierarchical model to measure perceived service quality considering three primary dimensions viz. interaction quality, physical environment quality and outcome quality consist of attitude, behavior, and experience (interaction quality); ambient conditions, design, and social factors (physical environment quality); waiting time, tangibles and value (outcome quality) respectively. In their approach, Brady and Cronin, emphasized on customers’ expectation and perception of different dimensions of services in order to measure service quality.

**Aragon et.al.(2003)** conducted a research in emergency department of hospitals and suggested the primary provider theory to measure patient satisfaction considering three latent variables or constructs viz. physician
service (SP), waiting time (SWT) and nursing care (SN). They applied multiple structural equation models for developing a hierarchical relationship between patient satisfaction and above-mentioned constructs. Three latent variables define the attributes of quality of health care service. They proved that overall patient satisfaction depends on SP, SN and SWT. They also pointed out that overall satisfaction is positively associated with two indicators – likelihood of patients’ recommendation of the health care unit and degree to which the service is worthwhile in terms of money paid by patients.

**Petersen, M. B. H. (2004)** in his journal found that some studies on the quality of the public health care sector in India. It has been observed that the quality of the public health care sector is quite low and inadequate. Patients are dissatisfied with the level of service provided in the public hospitals.

**Shi and Singh (2005)** explains that the perspective of patient satisfaction, quality has been explained by two ways – a) quality as an indicator of satisfaction that depends on individual’s experiences about some attributes of medical service viz. comfort, dignity, privacy, security, degree of independence, decision making autonomy and attention to personal preferences and b) quality as an indicator of overall satisfaction of individuals with life as well as self-perceptions of health after some medical intervention.

**Safavi, (2006)** Discusses that the patient satisfaction depends on three elemental issues of health care system. These are perception of patients regarding quality health care service, good health care providers and good health care organization.
H. Arasli, E.E. Haktan, K.S. Turan, (2008) explains that the personnel dealing with patients majorly are doctors, nurses, and staff at hospital. Thus the dimension evaluates courtesy, competency, friendly and caring attitude, polite and well-mannered and appearance as professional. Other researchers have recognized as ‘professionalism of staff’

E. Babbie (2009) indicated that his questionnaire is an attempt to reprogram and renew the dimensions which are influencing service quality. Although it is argued that reality is there to be studied, captured and understood, it can never be fully apprehended; only approximated. Thus the future studies need to adopt triangulation – ‘use of several different research methods to test the same finding’ to affirm the proposed conceptual framework.

2.9 HEALTH CARE IN INDIA

Healthcare in India features a universal health care system run by the constituent states and territories of India. The Constitution charges every state with "raising the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002.

Parallel to the public health sector, and indeed more popular than it, is the private medical sector in India. Both urban and rural Indian households tend to use the private medical sector more frequently than the public sector, as reflected in surveys.
Malnutrition

42% of India’s children below the age of three are malnourished, which is greater than the statistics of sub-Saharan African region of 28%. Although India’s economy grew 50% from 2001–2006, its child-malnutrition rate only dropped 1%, lagging behind countries of similar growth rate. Malnutrition impedes the social and cognitive development of a child, reducing his educational attainment and income as an adult. These irreversible damages result in lower productivity. Robinson, Simon(2008).

High infant mortality rate

Approximately 1.72 million children die each year before turning one. The under-five mortality and infant mortality rates have been declining, from 202 and 190 deaths per thousand live births respectively in 1970 to 64 and 50 deaths per thousand live births in 2009. However, this rate of decline is slowing. Reduced funding for immunization leaves only 43.5% of the young fully immunized. A study conducted by the Future Health Systems Consortium in Murshidabad, West Bengal indicates that barriers to immunization coverage are adverse geographic location, absent or inadequately trained health workers and low perceived need for immunization. Infrastructure like hospitals, roads, water and sanitation are lacking in rural areas. Shortages of healthcare providers, poor intra-partum and newborn care, diarrheal diseases and acute respiratory infections also contribute to the high infant mortality rate. Institute of Economic Growth University of Delhi (2011)
Diseases

Diseases such as dengue fever, hepatitis, tuberculosis, malaria and pneumonia continue to plague India due to increased resistance to drugs. In 2011, India developed a *totally drug-resistant* form of tuberculosis. India is ranked 3rd highest among countries with a high rate of HIV-infected persons. Diarrheal diseases are the primary causes of early childhood mortality. These diseases can be attributed to poor sanitation and inadequate safe drinking water in India. India also has the world's highest incidence of Rabies.

However in 2012 India was polio-free for the first time in its history. This was achieved because of the Pulse Polio Programme started in 1995-96 by the government of India.

Indians are also at particularly high risk for atherosclerosis and coronary artery disease. This may be attributed to a genetic predisposition to metabolic syndrome and adverse changes in coronary artery vasodilation. NGOs such as the Indian Heart Foundation and the Medwin Foundation have been created to raise awareness of this public health issue. *Centers for Disease Control and Prevention US* (2011)

Poor sanitation

As more than 122 million households have no toilets, and 33% lack access to latrines, over 50% of the population (638 million) defecate in the open. This is relatively higher than Bangladesh and Brazil (7%) and China (4%). Although 211 million people gained access to improved sanitation from
1990–2008, only 31% use the facilities provided. Only 11% of Indian rural families dispose of stools safely whereas 80% of the population leave their stools in the open or throw them in the garbage. Open air defecation leads to the spread of disease and malnutrition through parasitic and bacterial infections. Indian Heart Foundation (2012).

**Inadequate safe drinking water**

Access to protected sources of drinking water has improved from 68% of the population in 1990 to 88% in 2008. However, only 26% of the slum population has access to safe drinking water, and 25% of the total population has drinking water on their premises. This problem is exacerbated by falling levels of groundwater caused mainly by increasing extraction for irrigation. Insufficient maintenance of the environment around water sources, groundwater pollution, excessive arsenic and fluoride in drinking water pose a major threat to India's health. *UNICEF India* (2011)

**Rural health**

Rural India contains over 68% of India's total population with half living below the poverty line, struggling for better and easy access to health care and services. Health issues confronted by rural people are many and diverse – from severe malaria to uncontrolled diabetes, from a badly infected wound to cancer. Postpartum maternal illness is a serious problem in resource-poor settings and contributes to maternal mortality, particularly in rural India. A study conducted in 2009 found that 43.9% of mothers reported they experienced postpartum illnesses six weeks after delivery. Rural medical
practitioners are highly sought after by people living in rural India as they more financially affordable and geographically accessible than practitioners working in the formal public health care sector. Urban Rural Population of India (2012).

Rural medical practitioners are highly sought after by people living in rural India as they more affordable and geographically accessible than practitioners working in the formal public health care sector Kanjilal, B; et al (June 2007).

**Female Health Issues**

- **Malnutrition:** The main cause of female malnutrition in India is the tradition requiring women to eat last, even during pregnancy and when they are lactating.

- **Breast Cancer:** One of the most severe and increasing problems among women in India, resulting in higher mortality rates.

**Stroke**

- **Polycystic ovarian disease (PCOD):** PCOD increases the infertility rate in females. This condition causes many small cysts to form in the ovaries, which can negatively affect a woman's ability to conceive.

- **Maternal Mortality:** Indian maternal mortality rates in rural areas are among the highest in the world. "Chronic hunger and the status of women in India".
A study conducted by the Future Health Systems Consortium in Murshidabad, West Bengal indicates that barriers to immunization coverage are adverse geographic location, absent or inadequately trained health workers and low perceived need for immunization. Kanjilal, Barun; Debjani Barman, Swadhin Mondal, Sneha Singh, Mounita Mukherjee, Arnab Mandal, Nilanjan Bhor (September 2008).

2.10 NATIONAL RURAL HEALTH MISSION

The National Rural Health Mission (NRHM) was launched in April 2005 by the Government of India. The goal of the NRHM was to provide effective healthcare to rural people with a focus on 18 states which have poor public health indicators and/or weak infrastructure. Umesh Kapil and Panna Choudhury (2005)

According to National Family Health Survey-3, the private medical sector remains the primary source of health care for 70% of households in urban areas and 63% of households in rural areas. International Institute for Population Sciences and Macro International (September 2007)

2.11 TAMILNADU HEALTH CARE SYSTEM

Tamil Nadu is ranked among the high-performing States in India, in the area of human development. The State is noted for its low mortality rates and effective healthcare services. The State has a long track record of innovations in the health sector. It has pioneered many new approaches to enhance effective access to quality health care at low financial costs. Over the last few decades, healthcare in the state of Tamil Nadu has improved significantly, with more
people having increased access to medical care. There is a strong commitment to high performance in the health sector.

Despite the speedy progress and development, the State continues to face challenges in the healthcare sector that need to be dealt with in a phased and systematic manner. The broad areas that need addressing are

- Coping with non-communicable diseases (NCD)
- Providing the highest quality of healthcare
- Resolving equity-related issues
- Having an effective health financing system

**Health Policy of 2003**: To tackle these challenges, the Government of Tamil Nadu developed a Health Policy in 2003. The Health Policy aims to address key health challenges, combat non-communicable diseases and accidents, strengthen management of health systems and increase effectiveness of public sector healthcare services. The policy focuses on improving the health status of the general population, with special emphasis on low-income, disadvantaged and tribal communities, over the next two decades.

**The Tamil Nadu Health Systems Project**

The Tamil Nadu Health Systems Project (TNHSP), implemented by the Health and Family Welfare Department (Government of Tamilnadu), lends its support to the Health Policy of 2003 and focuses on improving the health status of people belonging to the lower socio-economic strata. New approaches to address non-communicable diseases, addressing the health needs of the tribal and partnerships with the NGOs form the core of this project. The Tamil Nadu
Health Systems Project will assist in fulfilling the aims of the Health Policy through the following interventions

- Increased access of health services for poor, disadvantaged, and tribal groups
- Developing effective interventions to address key health challenges
- Improving health outcomes and quality of service by strengthening management of the public sector health systems and by involving the nongovernmental sector
- Increasing the effectiveness and efficiency of the public sector hospital services at the district and sub-district levels

The TNHSP is structured on the following themes:

- Child health
- Indigenous peoples
- Health system performance
- Population and reproductive health
- Injuries and non-communicable diseases

This chapter presented both literature reviews and profile of health care system in India and Tamilnadu. It clearly identified gaps in the literature as well as the present conditions of different types of patients in the study domain.