1.1 INTRODUCTION

Health is fundamental to individuals and national progress in any sphere. It is a measure of the energy and productive capacity of any country. Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. As the slogan reveals, when health is absent, wisdom cannot reveal itself, art cannot be manifested, strength cannot fight, wealth becomes useless and intelligence cannot be applied. Today the concept of development has shifted from economic improvement to human resources. Human development has been accepted as an important goal of the Eighth Five Year Plan. The economic survey also stresses the same and makes it crucial for the long-term success of the economic reforms. Thus the long-term development of social sectors such as education and health is vital for sustaining high rates of overall economic growth.

In the early 1900s, the leading causes of death were infectious diseases such as typhoid and cholera. Though infectious diseases have been controlled, other illness that can be directly linked to life-style are now among the leading causes of death. Today, poor health is highly related to life style and many of the diseases can be avoided or treated effectively. Therefore, the health focus of today is on physical well being and a positive, whole-health approach which includes physical, intellectual, social and emotional well-being.

India, a rural-based country, has established many Primary Health Centres (PHCs) for ensuring rural health. Primary health care services provide continuity of care, health promotion and education, integration of prevention with sick care, a concern for community as well as individual health, community involvement and the use of appropriate technology. Primary Health Centres (PHCs) provide curative, preventive, promotive and rehabilitative health care services including higher referral
services and co-ordinate public health, family welfare programs, maternal and child care services and other community-oriented rural health programs\(^3\).

Health not only influences individual and social welfare; it is also an index of the inherent capacity of an individual to be able to do things. Besides, commanding a premium in the labour market, good health widens the capabilities of the poor and raises their consumption standards by avoiding diversion of their meager incomes towards costly and avoidable curative health care. The health status of the population is shaped by a variety of factors like education, income, food, water, sanitation, availability and accessibility to health care facilities\(^4\). Thus, the study of the health status of the population may provide another dimension to their socio-economic well-being.

Developing countries are now seeking to spend more and more on health in order to give a better quality of life to their people. In fact, investment in health is the result of both compulsions and awareness that have increased in the recent decades. The preamble of the constitution of World Health Organisation states that the enjoyment of health is one of the fundamental rights of every human being. The document of the WHO states that the hospital is an integral part of social and medical organisation. The function of hospitals is to provide service to the population, both curative and preventive and out-patient services to reach out to the family in its home environment. Thus, hospital is also a centre for training of health staff and bio-social research.

This study considers the influence of the physical environment quality on customer service evaluations. Ambient conditions relate to non visual aspects, such as temperature, scent, music, peace and tranquility and maintenance services. The second important sub-dimension of physical environment quality is the social factor, which refers to the number and type of people availing services and their behaviour. It
includes physical facilities, equipment and appearance of personnel, waiting room amenities, technical services and sitting arrangements\(^5\). Primary health care services substantially affect the general health of the population. However, many other factors also influence the quality and efficiency of primary health care services in developing countries. The WHO specifically points out that to some extent the deterioration in health status of developing countries are attributed to inadequacies in primary health care implementation and neglecting responsible factors such as commitment, allocation of financial resources to PHCs and community participation.

1.2 STATEMENT OF THE PROBLEM

Loss of health affects the efficiency as well as the productivity of the overall national production. Health does not mean merely the absence of disease but complete adjustment of an individual to external environment, physical and social. Thus, it is a positive state of well-being of the individual along with a harmonious development of physical and mental capacities.

Under the Constitution, health is a state subject yet central government’s intervention to assist the state governments is needed in the areas of control and eradication of major communicable and non-communicable diseases\(^6\). A broad policy formulation, medical and para-medical education along with regulatory measures, such as drug control and prevention of food adulteration are therefore inevitable. These programs and schemes improve the nutritional and health status of both male and female in the age group of above twenty and bring about the effective coordination in the work of various agencies involved in child development programs. It also enhances the mother’s capabilities to take care of the nutritional needs of her children.
The WHO defines “health as a state of complete physical, mental and social wellbeing…” as presented in her constitution and reechoed in the Alma Ata Declaration. These broad aspects of well-being are well beyond what the health sector alone can handle. Considered individually, the earlier stated strategies of PHC require a very wide range of inputs from many sectors. For example, literacy improvement is mainly the task of the education sector; developing appropriate technology is multisectoral but may require key inputs from the technology and industrial sectors and poverty reduction will draw from strategic initiatives of the economic planning sectors for multisectoral implementation. Thus, PHC strategies fundamentally call for multisectoral inputs.

One of the important reforms of the Family Welfare Program in India was the policy decision to replace the system of monitoring family welfare programs with a method specific target system. This Target Free Approach (TFA) was later replaced by a Community Need Based Approach (CNBA). This has resulted in a major shift in the program with a focus on decentralised, need based, participatory planning and a monitoring system which emphasises the quality of care and delivery of essential reproductive health services. Hence, this approach is fully reflected in the ongoing Reproductive and Child Health (RCH) Program, being implemented nation-wide.

Service quality is achievable within all industries. Those companies that do not produce products are where customers expect service quality as part of every purchase as observed by Cannie (1991). He further states that companies have entered a period where they perform their service better to become competitively advantaged over other companies. Customers in this new era focus on service quality far more than on any other factor. The only criteria that counts in evaluating service quality is defined by customers. Customers evaluate service quality
based on the perceptions created about the service received from the service provider as observed by Zeithaml et al (1990)\textsuperscript{10}. These perceptions are achieved from the customer expectation perception when the provider performs the service. Woodside (1991)\textsuperscript{11} argues that the need to integrate the processes and procedures for service design and delivery with organisational culture can be achieved by involving the employees in all processes and procedures. The employee, who is viewed as the internal customer, should be treated the same as the external customer. Both are customers who participate in ensuring that service quality is achieved and therefore should be accorded the same degree of interest and respect as observed by Olsen et al (1996)\textsuperscript{12}.

Former president Dr. Abdul Kalam has pointed out that the Government of India is importing medicines, worth about Rs.3000 crores every year, but the people living within India below the poverty line, are unable to directly access the medicines and drugs supplied by the government\textsuperscript{13}. They have to depend upon government hospitals for maintaining their health.

Indeed health is wealth. So the government needs to ensure the health of the villagers. For their welfare, the government has been taken necessary steps to improve their health. Primary Health Centres play a crucial role in ensuring the health condition of rural people. Hence, this study has been undertaken to analyse the awareness and approach of rural people towards health care and to assess the service quality of the health centres in Thoothukudi district.

\subsection*{1.3 OBJECTIVES OF THE STUDY}

The study is undertaken with the following objectives:

1. To analyse the demographic profile of the respondents and their awareness about health related aspects.
2. To examine the respondents’ opinion about the functioning of PHCs and their services.

3. To evaluate the impact of service quality on overall patient satisfaction and their loyalty.

4. To examine the perception of the staff working at PHCs towards their occupational climate.

1.4 HYPOTHESES

For the purpose of analysis, the following null hypotheses are framed:

\( H_01: \) There is no significant relationship between the demographic profile of the respondents and role of PHCs in rural areas, expectations from PHCs and kinds of treatment availed in PHCs.

\( H_02: \) There is no significant relationship between the demographic profile of the PHC staff and patients’ co-operation for treatment, patients’ behaviour and job satisfaction.

1.5 METHODOLOGY

1.5.1 QUESTIONNAIRE DESIGN

Two sets of questionnaire were prepared for collecting data: one from the beneficiaries of health centres and the other for the staff members working in PHCs. Most of the questions in the first are based on five point scale technique depending on the level of service quality attached to each variable. The second is related to the personnel working in PHC namely doctor, nurse, ANM, VHN and pharmacist and their perception towards their working climate.
1.5.2 SAMPLING PROCEDURE

In Thoothukudi district, there are 48 primary health centres in rural areas. Among these, 24 centres were selected covering a total population of 1,56,583 (2010 census). These 24 PHCs were selected based on the number of doctors, nurses, VHN and beds. The sample PHCs were classified into three levels i.e. high, medium and low in terms of staff strength. At each level, eight PHCs were taken into consideration. High level was determined where the number of doctors exceeds five; nurses three; VHN seven; and beds exceeding thirty in number. Similarly, medium level was fixed where the number of doctors ranges from 3 to 4; nurses range from 2 to 3; VHN range from 5 to 6; and beds range from 8 to 11 in number. Low level is fixed where the number of doctors and nurses is less than two; VHN less than four and beds less than six. The data were collected from about 1027 respondents selected using random sampling method covering the villages of Alwarthitunagari, Anandhapuram, Arumuganeri, Authur, Erachi, Eral, Kalugumalai, Karungulam, Keelachekkarakudi, Kulaseharapattinam, Kulathur, Mappilaiyurani, Megnanapuram, Mudalur, Ottanattham, Perilovanpatti, Petmanagar, Pudukkottai, Puthiamputhur, Puthur, S. Kailasapuram, Thenthiruperai, Vellalankottai and Veppalodai.

Under this study, the sampling size was confirmed by the RAO software\textsuperscript{14}. The confidence level of the study is the amount of uncertainty. So, a higher confidence level requires a larger sample size which is 95% of typical choices. There were 1,56,583 people available for random sample survey in and around the rural areas. Therefore, the recommended minimum sample size was found to be 384 for the current survey. However, the research sample size is 1027 which is much more than the required level. Similarly, the data was also collected from 207 staff respondents from the same 24 primary health centres.
1.5.3 COLLECTION OF DATA

Both primary and secondary data were collected. Primary data was collected through interview schedules and secondary data was collected through published articles, journals, magazines, books, newspapers and websites.

A structured schedule consisting questions pertaining to all the variables included in the study was used to collect the required data through direct personal interview. A pilot study was conducted by survey questionnaires with about 25 respondents. The completed questionnaires were checked and corrected. The omissions and errors were rectified by revisits to the fields. The final questionnaire was put to use among randomly selected beneficiaries and PHC staff. At the end of the data collection period, a total of 1027 beneficiaries and 207 PHC staff had responded and provided the data.

1.5.4 FRAME WORK OF ANALYSIS

After completion of the data collection, the filled up interview schedules were edited. A master table was prepared to sum up all the information contained in the interview schedules. With the help of the master table, classification tables were prepared which were taken directly for analysis. Version 13.0 of Statistical Package for Social Science (SPSS) was used to analyse the data. The collected data was analysed by using appropriate statistical tools like percentage, mean, standard deviation, chi-square test, descriptive statistical analysis, reliability test and exploratory factor analysis for arriving at conclusions.

1.6 SCOPE OF THE STUDY

The present study covers the area of Primary Health Centres in Thoothukudi District. It deals with Beneficiaries Opinion on Service Sector - PHC in Thoothukudi
District and the period of this study is from 2010 to 2012. The present study covers the rural areas and PHC staff in Thoothukudi District.

1.7 IMPORTANCE OF THE STUDY

1. This study aims to make people aware of the value of regular exercise, diet control, yearly body check-up as preventive measures to keep fitness.

2. This study identifies the types of diseases that are treated well in PHCs. This may be useful for the persons who want to avail such facilities and treatment in PHCs.

3. Those who propose to establish private hospitals in this area may find this study useful to decide which facilities are not available in this area.

4. The government authorities would be prompted to provide better health services and other facilities to the people based on the study.

1.8 LIMITATIONS OF THE STUDY

This study is mainly based on the data given by the respondents and staff which may not be cent per cent correct. Besides some of the other limitations are:

- This study is limited to health care service sector located in the Thoothukudi district primary health centres only.

- A considerable number of the respondents are illiterates. So perceiving and interpreting the action of respondents is cumbersome.

- The research work has not covered all the primary health centres of the district.

- The opinion of the non users who feel lack of technical facilities and improper treatment have also been considered for analysis.
1.9 CHAPTER SCHEME

The thesis is classified into seven chapters:

1. The First Chapter explains the introduction and research design, introduction, statement of the problem, objectives of the study, hypotheses, methodology, scope of the study, importance of the study and limitations of the study.

2. The Second Chapter deals with the theoretical aspects regarding health care services.

3. The Third Chapter documents the important reviews of previous studies related to the main study.

4. The Fourth Chapter discusses the perception of beneficiaries towards primary health centres.

5. The Fifth Chapter discusses the analysis of service quality in PHC as revealed in the data.

6. The Sixth Chapter discusses the attitude of staff towards the service in primary health centres.

7. The Seventh Chapter deals with the relevant and important findings, suggestions and conclusion of the study.

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