3.1 INTRODUCTION

Review of literature is an important part of any research and this serves as a background for the researcher to have a comprehensive knowledge about covered and uncovered facts in the previous studies. A number of studies have already been undertaken in the field of health. In advanced countries like the U.S.A. and Britain, marketing of professional services particularly hospital services gained momentum around three decades ago and hence, there are many studies in this area. In India, hospital service marketing is in its infancy stage and hence, there is not much literature as found in advanced countries in this area. Since, there are few similar studies done previously in this area, some of the available literature from foreign studies have been brought to highlight review of literature which is an important part of the study. A number of foreign studies and a few Indian studies have been undertaken in the field of health. Some studies have direct relevance to the topic and some have indirect bearing on the study. Some of them are reviewed and presented in this chapter.

Myrdal (1968)\(^1\) pointed out that housing standards vary but are frequently abominably low in the city slums and rural districts. Over crowding with inadequate sleeping arrangements abets the spread of transmissible diseases, especially as diseased family members can rarely be hospitalized. Generally speaking, the housing situation shows little sign of improvement anywhere in rural and overcrowded areas. In the growing cities at least it is probably getting worse. As with clothing the cause is not only poverty but also poor habits.

Banerji (1975)\(^2\) in his paper lays emphasis on the role of ecological, social, cultural, political and economic factors in shaping the health care system of a country. He says that vast sums of public funds are spent in establishing expensive and
sophisticated hospitals, in cities to serve mainly the privileged classes. Again a disproportionately large segment of the limited resources that are left for preventive services are spent for urban population. He criticises the existing approaches to the formulation of health strategies in India and gives suggestions for alternative health strategies even within the existing constraints.

**Philip Kotler and Corner (1977)** studied “Marketing Professional Services” to explicate the role of marketing in professional service firms. The conclusion drawn by this study responds to the question facing professional firms i.e. whether to involve in marketing or not. In the field of marketing, the question is how to do it effectively. As the firm’s competitors resort increasingly to install an organised program for business development, the professional health care firms can no longer remain indifferent to the discipline of marketing.

**Athreya (1978)** pointed out that the demands on the hospitals are constantly increasing but, the facilities remain stagnant or do not correspond to the increasing demand as that they are starving for funds.

**Banerji (1978)** observed that many factors influence the health status of a population. The health of a population is influenced by social and economic factors such as nutrition, water supply, waste disposal, housing, education, income and its distribution, employment, communication, transport and the social structure.

**Donabedian (1980)** suggested the structure-process-outcome model. According to him, this model provided the criteria for what constituted “good care”. The structure included relatively stable characteristics of health care facility such as equipment, operation theatres, rooms, personnel, organisation of care. How, health care service was technically delivered and the outcome or the result of health care service received by the patient were also important.
Panikar. G.K., (1980)\(^7\) in a study “High cost of medical care in Kerala” outlined the comparative cost of medical care in southern parts of India. Per capita state government expenditure on health in Kerala was among the highest in 15 major states in India.

Shortell and Taylor et.al (1981)\(^8\) found that organisational research within health care services delivery institutions is limited by lack of reliable and valid measures of performance.

Yesudian (1982)\(^9\) exposed the factors responsible for the poor health status of metropolitan cities in spite of spending large amounts on health services. He states that so long as proper planning, organising and distribution of services do not receive the attention of the authorities, there will not be any improvement in the situation.

Bose and Desai (1983)\(^10\) stated that the failures as admitted in the policy statement, are largely due to “wholesale adoption of Western models which are irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. This leads to the neglect of the preventive, primitive, public health and rehabilitation aspects of health care and to the policies of education and training that widen the gap between the health personnel and the rural masses.

Merchant (1983)\(^11\) lamented that no guidance is given to the patient proper dosage, frequency of medicines and possible side effects or adverse reactions while distributing drugs to the patients in the hospitals. He suggests appointing persons with pharmacy degree or diploma holders to overcome the said shortcomings.

Panikar (1984)\(^12\) pointed out that it is needless to say that the success of the health care programs, preventive and primitive measures would depend upon the health consciousness of the people, their willing co-operation and proper use of facilities. It has been widely recognised that health education plays a critical role in these respects.
Health education is different from general education and the latter does not necessarily ensure the former. Health education involves the translation of what is known about health into definite individual and community behaviour patterns through education. Thus, it includes both knowledge on health related matters and behaviour in line with that knowledge.

Maurice (1984) pointed out that the organisation of health services must keep pace with the growing needs and resources of a country. If health services lag behind, the whole community people will suffer a lot. On the other hand, the patterns of health services organisation of a country helps the process of its general economic development.

Chalkey (1986) stated that health plays an important role in the economic development of the country. Development essential by means development of men and not merely the development of materials and machinery. For this purpose the significant tools are education and health.

Winston (1986) made a study on “The Evaluation of Hospital Marketing” and concluded that the evaluation of the marketing concept was through health education by the public sector health departments.

Cunningham et al (1988) shown the importance of counseling in an integral part of early intervention to enhance parental confidence, competence and use of service. Enhanced services and positive attitudes to young disabled children were both improvements in consequence.

Meera Chatterjee (1988) pointed out that the National Health Policy statement suggested that the idea of “Health for All” is a clear commitment at the national level. The commitment of the states however, in implementing this policy may vary widely as it has in the past. Therefore, a mechanism needs to be instituted to
ensure that all states implement the basic health care envisaged by the policy. The central councils must be strengthened so that both carrots and sticks are applied to their recommendations.

**Sivaswamy Srikantan (1989)** examined family planning and fertility control in India. He observed that contraception and sterilization have gained acceptance in India and are widely prevalent among all communities. The level of fertility varies community wise, by level of education of the wife and that of her husband. And these variables also affect family planning through family size norms and parity at acceptance.

**Woodside et al (1989)** observed that in health care industry, patient’s perception of service quality positively influences patient satisfaction, which in turn influences choice of health care provider.

**Cronin and Taylor (1992)** pointed out that human life is sacred and health care deals with human lives. This places tremendous responsibility on the shoulders of health care service providers to maintain a high level of service quality and to constantly strive to improve it. The importance of service quality in health care is obvious. People travel long distances to receive affordable, timely and high quality medical care.

**Henry Mosley (1992)** observed that in his experience there was a transfer of health resources from the poor to the rich. The rich pay more, but they also expect more. Because, they are paying for open-heart surgery and other advanced techniques, they expect well trained doctors and the best facilities, which are expensive. The government generally provides these resources, which is a political reality in the health system that must be dealt with. He agreed that much can be done to make
health care more economical; the government should not only encourage providers to offer innovative, low-cost health care but should also encourage consumers to demand it.

**Francis (1993)** pointed out that the most important factor producing differences in health is the economic condition. It can be seen that the disproportionate investment of personnel and other resources catering to the affluent. The rich and the powerful often get far better health care than the poor and the marginalised. Health care in an unjust society cannot be just. Yet, health is an area, which can lead to a more just society.

**Renhardt (1993)** pointed out that every country, industrial or not, will always run a two-tier health care system. That is the ideal, the best it can achieve. The large bottom tier of the system would serve 70 to 80 percent of the people. That tier, where health care is viewed as a public good, would be public financed by people paying into an insurance pool according to their ability to pay. A private system of health care would serve the top 20 percent of the population, with private hospital rooms and government food if they wished. In that tier, people would pay through private insurance or out of their pocket. There would be no public health provision and if people wanted to buy unnecessary operation that they might kill them that would be their problem and their choice. Reinhardt thought that the one tier Universal Health System advocated by left-wing or centrist thinkers would never come about. He felt that failure to recognise this makes the best enemy of the common good, which is the tragedy of health policy.

**Cronin and Taylor (1994)** revealed that patient satisfaction and healthcare service quality are two empirically different constructs. Contrary to the existing healthcare marketing literature, a model for distinguishing between the two was provided by the authors. The study results suggest that healthcare managers can dispense with the
SERVQUAL service quality measurement scale and concentrate on the SERVPERF scale instead.

**Dadibhave, R.V., (1994)**\(^{25}\) studied inter state health care services in India and found that the disparity in health status across the states of India is widening. In a poverty-stricken country like India, the government has to play a major role in improving the health of the people. Indirect spending through infrastructure will have a more positive impact on the health status. Expansion of investment on health infrastructure in rural areas in general and rural areas of backward regions in particular will reduce the rural-urban as well as inter-state disparity in health status. Universalisation of education, especially female education, will not only improve health status but will also help to solve other problems. e. g. population problem.

**Srinivasan (1994)**\(^{26}\) suggested that for increasing the accessibility of rural health care services and correcting regional disparities in the shortest possible time, the government should have the following goals: expanding the network of medical facilities and health services; increasing the accessibility of health services in rural and tribal areas; correction of disparities in the provision of health services between rural and urban areas; intensification of national health programs; greater emphasis on environmental sanitation; improving the quality of health services; and providing effective referral services.

**Brien et al (1995)**\(^{27}\) observed that quality improvement in hospitals is positively associated with more favourable perceptions of the hospitals.

**Ravi Duggal (1995)**\(^{28}\) made a study on “Health Expenditure Across States,” and found that expenditures across states show a declining trend especially after the 1980s. The declining trend and under funding by most of the states have been major reasons
for the non-functioning of public hospitals and mushrooming of unregulated private hospitals.

Loyalty is defined as the likelihood that a customer of a healthcare service provider expects to do business with the organisation in the future and engage in positive word-of-mouth communications about the service as observed by Zeithaml et al (1996)\textsuperscript{29}.

Sewell (1997)\textsuperscript{30} observed that patient and professional quality expectations have increased along with government pressure to contain service costs.

There are eight dimensions of healthcare service delivery: effectiveness, efficiency, technical competence, interpersonal relations, access to service, safety, continuity and physical aspects of healthcare as emphasized by Brown et al (1998)\textsuperscript{31}.

Jun Peterson et al, (1998)\textsuperscript{32} found that patients are typically not capable of assessing the technical quality of the care they receive. It would be very difficult to adequately raise the patient level knowledge about the technical aspect of quality. Pamphlets on basic preventative medicine and general descriptions of diseases and illnesses can be published and distributed. Due to the complex nature of the technical quality, there can, however, only be limited results from such a campaign. The better way to increase perceived quality may be through focusing more on the functional dimensions of quality. This may be achieved through training physicians to better communicate with patients, making more pleasant and accessible facilities available and prioritizing employee behaviours that are friendly understanding and caring the patient.

Castaneda-Mendex (1999)\textsuperscript{33} found that competition reinforces the need for improved performance measures in health care systems. The intent of the study was to develop a valid and reliable instrument based upon the JCAHO dimensions of hospital service quality.
Ware et.al., (2000) noted that patient satisfaction is affected by the characteristics of the service providers and medical services.

Wazzan (2000) conducted a study on Patient Loyalty versus Satisfaction: Implications for Quality and Marketing Strategies. This mixed method study of three competing hospitals in Lebanon differentiates among the organisational factors for health care delivery that affect the intention to return and the amount of satisfaction and also measures their respective impacts. The study also examined these relationships across different department specialty. The findings demonstrate that factors that increase patient satisfaction differed from those that influence a patient’s intention to return, which in turn differed from those that influence a patient’s decision to come back or to seek another hospital.

The subject of online health information became a subject of scholarly interest due to the growth of health-care consumer’s dependency on the internet for health care information. Not only is a large percentage of consumer’s depending on the internet for this information, but 70 percent of those who search for health information online use such information to make important health decisions as observed by Berland, (2001)

A hierarchical approach has been suggested by Brady and Cronin (2001) which concentrates the primary dimensions into 1. Interaction quality, 2. Physical environment quality and 3. The outcome quality with each of these primary dimensions has sub-dimensions, and each sub-dimension has a reliability item, a responsiveness item and an empathy item.

Sower et.al (2001) empirically sought to confirm the nine dimensions in the JCAHO scale which are incorporated the SERVQUAL. They developed five dimensions and came up with the KQCAH scale for the determination of service quality of hospitals in the United States of America.
Taylor H, (2003) found that young adults aged 18 to 29 have the highest percentage of any group who search for online health information. The research also shows that “web health information requires a reading level that prohibits optimal access by some low-literacy adults”.

Hanauer, (2004) revealed that one of the advantages of using the internet as a source for health-related information is convenient access to information from multiple sources and the ability to seek information on sensitive topics anonymously.

Akash Acharya (2005) observed that health indicators in India have seen substantial improvements in recent decades but quality and affordable health care services continue to elude the poor. Government provided health services only partially meet the needs of the rural and urban poor in the informal sector and making equitable and affordable medical care accessible to this segment remains a challenge. Health care expenditure cuts poor households budget in two ways, not only do they have to spend a large amount of money and resources on medical care but, they are also unable to earn during the period of illness.

Perez, (2006) found that the internet has a potential to change the culture of healthcare in which patients will be partners in care and not merely recipients of care. This has had a profound impact on society and has changed relationships between patients and their doctors. Instead of a patient calling the doctor to consult him or her about an ailment first, many are consulting the internet. In a nationwide telephone survey, it was discovered that 50 percent said health information obtained online influenced the way they ate and exercised, 70 percent said health information retrieved from the web influenced their decision about how to treat an illness or condition, 50 percent said the web information led them to ask a doctor new questions
or get a second opinion from another doctor, and 28 percent said the information from the health website affected their decision about whether to visit a doctor or not.

Rahman Mohammed A. (2006)\(^{43}\) conducted a study on “Measuring and explaining the managerial efficiency of private medical clinics in Bangladesh”. The study found that there is considerable inefficiency in the way medical clinics in the private sector currently operate. The study determined that as much as 1146 beds, 406 doctors, 600 nurses and 2475 staff could be reduced if all the clinics operated at the “best practice” level. In contrast, an additional 14386 outpatients, 2844 surgical patients and 6404 gynecological patients could be treated with existing resources.

Yesilada and Direktor (2010)\(^{44}\) pointed out that service quality has a significantly positive effect on patient satisfaction in public and private hospitals. Therefore, service quality perceived by a patient will induce patient satisfaction.

### 3.2 CONCLUSION

By using the previous studies, the researcher has been able to reconceptualise some points and found some gaps in health care related studies. On the basis of the above said findings, the researcher has made an attempt to pursue the study on availability, accessibility and affordability of health care services provided by the primary health centres in Thoothukudi district. In order of fill up the gap, this research area has been specifically confined to district level study.

### REFERENCES


43. Rahman A. Mohammed, Measuring and Explaining the Managerial Efficiency of Private Medical Clinics in Bangladesh, 2006, pp: 84 - 152.