CHAPTER 2
REVIEW OF LITERATURE

2.2. Introduction

The review of literature relating to the present study are classified as follows:

- General reviews relating to the present study
- Reviews relating to the public and private sector in health care
- Utilisation and satisfaction related reviews relating to health service and
- Reviews relating to service quality assessment.

2.2.1. General reviews relating to the present study

Reviews relating to expenditure on health sector and growth, value of ethics in health care delivery, and other core issues are considered in this section.

Jehani (2012) reported that the size of the Indian healthcare delivery market as Rs.2.6 lakh crore in 2011-12 which is expected to almost double to Rs.4.7 lakh crore in 2016-17. Further, he listed the major reasons for the immense potential of the healthcare market in the long-term, such as a shift in demographics (an increase in population and rise in life expectancy) and a higher purchasing power (due to rising income levels and rising literacy levels).

The paper by Buckley and Cuff (2012) presented the results of a revealed-choice experiment testing the theoretical predictions of a model of a mixed system of public and private finance. In the context of a mixed system of health care finance, it investigated behavioral responses to change in the public sector allocation rule (needs-based vs. random), the supply of health care resources, and the size of the public health care budget on the following outcomes: the equilibrium market price for health care resources, the number of individuals who purchase private insurance, the probability of health treatment in the public system for those without private insurance, the health status of individuals left untreated, and the incomes of individuals who receive treatment. The findings are generally consistent with the predictions of the theoretical model, although individuals consistently exhibit greater willingness’s-to-pay for private insurance than predicted resulting in a larger than predicted amount of private insurance being purchased. A commonly used risk-
aversion measure only partially explains this observed deviation. It also found that, relative to a system of public financing only, a mixed system of health care finance results in higher health care prices and sicker, poorer people being left untreated.

The commentary article by **Duggal** (2012) reproduced the discussion that had taken place in Third People’s Health Assembly, organized by the People’s Health Movement in July, 2012 in Cape Town, South Africa. A wide range of discussion were held in health and related issues, including the political and economic context of health, comprehensive primary health care, social determinants of health, universal coverage, mobilising for health, etc. It also highlighted the issue of creating fiscal space in public budget to make adequate budgetary commitments for health care.

The paper by **Gayathri** (2011) attempts to develop a defined set of financial indicators to track the health budget and expenditure at the national and at the state level and to review the healthcare financing trends in Karnataka using the indicators developed for the purpose (i.e., Gross State Development Product, Revenue expenditure, capital Expenditure, Per capita real expenditure, etc). It analyzed the flow of funds from all sources and has developed 18 indicators to identify the magnitude of resources flowing from each source and the activities into which they are flowing. A comparative picture of healthcare spending by the southern state governments (Tamilnudu and Kerala) in terms of its share in total expenditure, social services expenditure and the GSDP over the last two decades was made, that showed that both the states are ahead of Karnataka in terms of all the indicators. It also noticed that there is a declining share for health care services until 2005-06 in Karnataka and other states because of the fiscal stress that has been experienced by the government both at the central and state levels.

**Chakraborty G.** (2010) has observed the patterns of public health expenditure in India. The main objective of his analysis is to examine the size, distribution, trends, composition and rate of growth of union and state health expenditure during the period of 2001-2002 to 2008-2009.

A book by **Ashokan** (2009) contains contributions of a large number of academicians who participated in a national conference on Health Economics held by the Economics department of the Nehru Arts and Science College, Kanhangad in
Kasargod district of Kerala, in January 2008. The papers included in this volume cover a wide variety of issues ranging from the implications of the operations of international organizations such as World Trade Organization (WTO) on the health conditions of the populations of different nations, to the economic burden of diseases for the public and drug policies of the governments. A sizable proportion of the discussion is based on field level data collected from Kerala.

Bhattacharya (2009) has analysed the intra-state disparity in government expenditure on social sector. For the purpose of analysis he has taken three major heads i.e., Education, Health and Sanitation, and the six states namely Bihar, Uttar Pradesh, Madhya Pradesh, Chhattisgarh, Jharkhand and West Bengal. With the help of simple statistical tools like Lorenz Ratio, Standard Deviation, Coefficient of Variance and Disparity Ratio he concluded that Chhattisgarh was the only one state that has spent its resources in the social sector in the most equitable manner.

Duggal’s (2009) paper analysed the public health budgets in the context of the National Rural Health Mission (NRHM). By listing many reasons for the failure of NRHM in increasing funds in the public health sector i.e., fungibility with the states, central control on health resources etc, it stated that unless radical changes in budgetary and financing mechanism are put in place by granting full autonomy to those who directly run the public health system, the NRHM flagship will continue to sink.

Claeson et al., (2009) states that the MDGs to be achieved by 2015, of which nearly half concern with health: eradicating extreme poverty and hunger, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases. While some goals have been met, for example, the poorest quintile of the population within countries is on target to reach the nutrition goal; the child mortality goal is unlikely to be achieved in most low-income countries. All countries can make progress- the ability to scale up by 2015 will depend on a combination of sound policies and additional funding.

Duggal (2006) examines the allocations for health in the budget in the light of the commitments made in the National Common Minimum programme and the trend
in state government’s expenditures with special reference to National Rural Health Mission.

Bhat and Jain (2004) made an analysis of public expenditures on health using state level public health expenditure data. “The findings suggested that at state level governments have target of allocating only about 0.43 per cent of State GDP (SGDP) to health and medical care which does not include the allocations received under central sponsored programmes such as family welfare. They opine that given this level of spending at current levels and fiscal position of state governments the goal of spending 2 to 3 per cent of GDP on health looks very ambitious task. The analysis also suggests that elasticity of health expenditure when a SGDP change in only 0.68, which is for every one percent increase in state per capita income the per capita public healthcare expenditure has increases by around 0.68 per cent.”

Chauhan (2001) opined that health is determined not only by medical care but also by determinants outside the medical sector such as environment, socio-economic factors, information and communication, availability of health services, utilisation of health services, age structure of the population etc. Public health approach is to deal with all these determinants of health which requires multi sectoral collaboration and inter-disciplinary coordination. They stated that high burden of disease, disability and death in India can only be addressed through an effective public health system. In continuation to this, they stated that rural areas report more deaths due to communicable, maternal, prenatal and nutritional conditions (41%) and on the other hand, urban areas reports higher proportion deaths from non-communicable diseases (56%).

Rahman and Smith (2000) have reviewed the use of location-allocation models in health service development planning in the developing nations. The purpose of their review is to examine the suitability of these methods for designing health care systems and their relevance to overall development problems in developing countries.

Duggal and Jesani (1992) talk about the importance of ethics in medical practices. They points out that enforcement of ethics needs to be based on principles
of non-malefice, beneficence, autonomy and justice. At the same time, throws light on serious issues like malpractices, organ trading, unethical practice, commercialisation of health care so on and calls for powerful patients’ movement in order to uphold the ethics and bring reforms in the system.

The book by Wilkin .D. et al., (1991), has addressed the problems of measurement in primary health care. It is an important reference text for primary-care physicians and nurses, health service managers and researchers, and specialists in public health. This book provides user's guide to variety of instruments designed to measure different aspects of patient outcomes in primary health care. The authors have selected and critically reviewed measures of health status and patient satisfaction. Most of the questionnaires and schedules discussed are reproduced to enable the user to judge their suitability for a particular purpose. The book includes an introduction to conceptual and methodological issues in the measurement of needs and outcomes in health care.

2.2.2. Reviews Relating to the Public and Private Sector in Healthcare

Prabakar (Shyama Rajagopal, 2012) Managing Director of Kerala Medical Services Corporation Ltd. (KMSCL) told The Hindu that the lack of database on the quantity of medicines maintained with the government hospital has been the major reason for the shortage of required drugs.

The article in the newspaper THE HINDU (2011) Industrial body Associated Chambers of Commerce and Industry of India (Assocham) has given a statement that rising income levels and exposure to international standards of quality have led to increasing demand for quality private healthcare, and the size of the Indian private hospitals market is expected to touch $54 billion by 2014 from $26 in 2011. It further quoted that most people in the country preferred private hospitals for check-ups and the private players are increasing their investments in smaller cities.

In THE HINDU news daily an article by Bennur (2011) reported that due to increase in the population of Mysore city the demand for public health care services is on the rise. Bearing in mind the need for public healthcare facilities to match the rising population, the district administration has proposed a 250-bed government
hospital with tertiary care facilities in Mysore and is awaiting government’s approval.

In an article in THE HINDU – Kuruvilla (2011) stated that the health service in India is in bad shape. The withdrawal of the government from the service sectors has created havoc. It has resulted in untold miseries to millions. It has left the healthcare sector high and dry. Private enterprises and corporate bodies have grabbed this sector. The hardest hit in this game are the poor. The supreme challenge before us is the provision of reasonable healthcare for one and all. Taking china as an example, author says that when the Chinese faced a shortage of medical personnel, they produced large number of barefoot doctors. It did not work because the training imparted to them was inadequate and inappropriate. India is also on the verge of committing the same mistake. The central government plans short-term medical courses to produce half-baked doctors for our rural poor. Further, he reported that the health centres in India are not equipped well, nor are they manned by adequate trained staff. The problem is not one of numbers, but of quality and their uneven distribution.

Kannan (2011) reports in an article in The HINDU that some of the Primary health centres in Tamilnadu (Thogamalai PHCs in Karur district, Devikapuram PHCs, Perungattur PHCs, Kotappatti tribal PHCs) have taken to blogging about facilities at their centres like - facilities available at the PHCs, the various government schemes and how to access them, forms to be downloaded for the purpose etc. in order to reach the people of their areas.

Eggleston et al., (2010) in their working paper, analyzed the government and private roles in health service delivery in China. Using 2004 data from over 360 government-owned and private hospitals in that province, they find that private hospitals serve an overlapping but distinct market. They also document differences in staffing and financial performance between two types of hospital but no systematic differences in simple measures of utility, controlling of size, location, case-mix and other confounding factors.
Huang et al., (2009) examined the role of private health care provision in China and discussed the implications of increasing private-sector development for improving health system performance by using secondary data. They suggested that policymakers in China should recognize the role of private health care provision for health system performance, and then define and achieve an appropriate role for private health care provision in helping to respond to the many challenges facing the health system in present-day China.

Yip and Mahal (2008) analyzed how well the health care systems of China and India have performed and what determines their performance. To facilitate comparisons between China and India, they adopted an analytical approach that is commonly used in evaluating health systems and designing health care reform. Based on the analysis, they suggested that money alone, channeled through insurance and infrastructure strengthening is inadequate to address the current problems of unaffordable health care and heavy financial risk in these two countries, and the future challenges posed by aging populations that are increasingly affected by non-communicable diseases.

According to Duggal et al., (2005) health policy in India has shifted its focus from being a comprehensive universal healthcare system as defined by the Bhore Committee (1946) to a selective and targeted programme based healthcare policy with the public domain being confined to family planning, immunization, selected disease surveillance and medical education and research. The larger outpatient care is almost a private health sector monopoly and the hospital sector is influenced by the market forces. The decline of public investments and expenditures in the health sector since 1992 has further weakened the public health sector thus adversely affecting the poor and other vulnerable sections of society.

D'Cruz and Bharat (2001) paper provided a perspective on India's health care system in the post-independence period in describing India's public, private and voluntary health sectors; it highlighted some of the reasons behind the marginal improvements in health status in the country.

Duggal’s (2000) paper gives a insight information on the growth of the health sector in India in the historical context along with major shifts i.e., in the growth of
medical human power, health care facilities, production of drugs and medical equipments. It concludes that drastic change in health policy and reorganization of the entire health care system are essential in order to achieve universal health care provision.

The Paper by **Berman** (1998) discussed the influence of government policies on the development of private health sector from different prospects i.e., public production or provision, economic incentives or disincentives in the form of taxes or subsidies, regulation and licensing, intervention in factor or input markets and public information.

**Berman**’s (1998) paper argued that, given the current situation in many countries, long-term strategy to develop a “national health service” type model of health care provision is misguided and wasteful. The current and potential role of nongovernment health care providers in achieving high levels of access to basic services is highlighted, using data from an extensive analysis of health care financing and delivery in India.

The study done by **Bhat** (1993) reviewed the role of the private health care sector in India and the policy concerns it engenders. It suggested that policy makers in India should take serious note of the growing influence of the private sector in providing health care in India. Policy interventions in health should not ignore their existence and this sector should be explicitly involved in the health management process. It argued that regulatory and supportive policy interventions are inevitable to promote this sector's viable and appropriate development.

**Phadke** (1993) tried to study the different aspects of the private medical sector such as general practitioners, consultants, hospitals, laboratories, medical colleges, etc., with a view to analyze its appropriateness in fulfilling the health care needs of the Indian people and to find out the reforms which are needed to make it fulfill its role.

The paper by **Duggal and Nandraj** (1991) has dealt with regulation that exists in the private health sector. Also, issues relating to a comprehensive regulation system for the private sector are thrown up for debate.
2.2.3. Utilisation and Satisfaction Related Reviews in Health Services.

In this section an attempt is made to review the literature relating to the utilisation of health care services and satisfaction from its access.

McKernan.S.C et al., (2012) tried to explore the geographical distribution of primary care dentists, physicians and pharmacists in Iowa. They also examined whether a hierarchical relationship existed or not among dentists, physicians and pharmacists in Iowa. They found that the number of independently owned retail pharmacies declined rapidly in rural communities between 2003 and 2010 because of economic pressures and changing demand pattern.

Kannan .R. reported (2012) that shortage of health human resources was a major issue in the country; its severest impact was in the rural areas. Further, she stated that crunch of human resources is probably hampering the implementation of the progressive NRHM programme in states, and thereby, access to health care in rural areas. Coming to Karnataka’s case, she stated that the state is in the better performers list with 10 percent of vacancies in health human resource.

Reddy .N. et al., (2012) have assessed the infrastructure facilities and availability of manpower in the SCs of Chittoor district. A total of 34 SCs were selected by multistage and stratified random sampling technique. Microsoft Excel was used for data analysis. The deficiency was found in the availability of health workers male and female in the study SCs. Thus, they have suggested (1) the need of considerable improvements in the physical infrastructure and manpower availability at the SCs as per the Indian Public Health Standard (IPHS); (2) better control of medical officers and health supervisors visiting the SCs at least once in two weeks.

A systematic review by Rosano et al., (2012) examined the relationship between avoidable hospitalization (AH) and accessibility to PHCs in different countries. The study ended up with the same conclusions as what previous study stated i.e., existence of inverse relationship between PHCS accessibility and rates of AH.

Põlluste and Kallikorm (2012) in their cross-sectional explained the possible determinants of satisfaction with access to health services in patients with
rheumatoid arthritis (RA). Of the 2000 randomly selected Estonian adult patients with RA, a total 1259 completed the survey. Regression analysis was used to analyze the predictors of patients' satisfaction with access to health services. The results of their study demonstrated that about half of the Estonian RA patients are satisfied with their access to health services. Factors that had a negative impact on satisfaction included pain intensity, longer waiting times to see the doctors, as well as low satisfaction with the doctors. Transportation costs to visit a rheumatologist and higher rehabilitation expenses also affected the degree of satisfaction. Patients who could choose the date and time at which they could visit the rheumatologist or who could visit their “own” doctor were more likely to be satisfied than patients whose appointment times were appointed by a healthcare provider. In addition, the satisfaction with one’s Family Doctor and rheumatologist played a significant role in people’s satisfaction with their access to health services.

The study by Rahman and Capitman (2012) examined 67 primary health care centres operating in the San Joaquin Valley, California, and explored the factors that may have contributed to productive efficiency gains. The study used the Data Envelopment Analysis (DEA) technique to measure efficiency of the clinics and then used Tobit regression analysis to understand the factors that affected efficiency. It found that clinics that employed relatively more "unlicensed" supporting practitioners compared to "licensed" practitioners were more likely to be efficient. The results also showed that clinics that employed fewer physicians compared to all "licensed" practitioners were likely to be more efficient. In addition, providing transportation services to patients also enhanced clinics' efficiency.

Chen et al., (2012) aimed to explore Taiwanese patients’ decision-making process to access health care and how the cost issue impacts patients’ access to health care and explored patients’ cost-saving strategies. They found that the physicians’ reputation, tiers of hospitals, and the convenience of transport and registration were the three major reasons why people accessed different medical facilities.

According to Balarajan et al., (2011) despite improvements in access to health care in India, inequalities are related to socioeconomic status, geography and gender, and are compounded by high out-of-pocket expenditures, with more than
three-quarters of the increasing financial burden of health care being met by households. They identify key challenges for the achievement of equity in service provision, and equity in financing and financial risk protection in India. Use of equity metrics in monitoring, assessment, and strategic planning; investment in development of a rigorous knowledge base of health-systems research; development of a refined equity-focused process of deliberative decision making in health reform; and redefinition of the specific responsibilities and accountabilities of key actors are needed to try to achieve equity in health care in India.

Ergler et al., (2011) examined the access to health care by poorer residents in Chennai, India. It revealed constraining and enabling conditions for impoverished users seeking treatment. They used Sen's entitlement approach with Penchansky and Thomas' work on access to health care. It suggested that analyses of affordability and physical access to health care in less developed countries should include a focus on emotional dimensions of utilization. In other words, there is a need to consider not only effective access to health care, but also effective dimensions of treatment for poorer citizens.

Ray et al., (2011) conducted a cross sectional observational study to find out the extent of utilisation, strengths, weaknesses and gaps in health care delivery system in West Bengal. Two stage sampling at district level and then at block level was done. Thus, at first stage three districts from different divisions of West Bengal namely Murshidabad from Presidency division, Uttar Dinajpur from North Bengal division and Purulia from Burdwan division were selected and at second stage to have a wider coverage at the district level, in each district three blocks were selected randomly. The results conveyed that: (1) female participation was high in study; (2) out of 672 episodes of illness (based on 15 days recall), 32.89 percent episodes did not avail any health care facilities for treatment; (3) majority of the clients utilized government health facilities i.e., CHC, PHC and SC, followed by private practitioners and quacks or unqualified practitioners; (4) an overall utilization of government health facilities at the block level was better (38 percent) than the earlier studies excepting tribal areas; (5) curative services were most in demand at the government health facilities; (6) the long waiting hours at the facility, distance and poor communication facilities were opined as the reasons for poor utilisation rates of government health facilities.
particularly in hilly and tribal areas; (7) good treatment (>60 percent) was considered as the main reason for utilizing the private health facilities in study area against government (27 percent).

On the basis of the findings the study has suggested the followings: (1) awareness to avoid the unnecessary referral; (2) strong need of improvement of post natal care; (3) introduction of a module based training to improve the interpersonal relationship and communication skills of the all public health professionals; (4) need to maintain cleanliness of the premises, face-lift, and clean toilet with privacy and availability of safe drinking water facilities to improve client satisfaction in rural health care delivery systems.

According to the study conducted by **Pune-based DY Patil Medical College and voluntary group India Health Progress** (2011), nearly 58 percent of the respondents consider poor infrastructure (Inadequate buildings, equipment and instruments and irregular staff) to be the main barrier in accessing healthcare facilities in the country. “Of the total respondents in the survey, only 31 percent expressed inability to seek treatment in the past six months due to financial constraints,” it stated. Out of 3,424 respondents, 80 percent respondents did not have access to health insurance cover.

**Pratheeba**’s (2010) has critically evaluated the various government health policies and examined their adequacy and relevance in the light of prevailing health needs. To assess the health system performance in Indian states and to study the efficiency of expenditure on health care services it employed both descriptive statistics and econometric estimation techniques.

The study identified a bias in the distribution of hospitals as well as beds in the urban areas thereby depriving the rural areas of these facilities and also it identified that the real expenditure on all health components of health care –water, supply medical and public health has declined towards the late nineties until 2004-05. It concluded that the preference is more towards private care due to lack of satisfaction, low accessibility and long waiting period faced in the government facilities.
Nteta et al., (2010) study was designed to investigate the accessibility and utilization of the primary health care services in three community health care centres in the Tshwane of the Gauteng Province, South Africa. Data were obtained from participants attending three Community Health Care Centres in the Tshwane Region using self-administered structured questionnaires. A document review of the Community Health Care Centres records was conducted to investigate the utilization trends of the services provided and descriptive statistics were used to analyze the data obtained. The results showed that the Community Health Care Centres in the Tshwane Region are accessible to most participants who lived within 5 km of such centres and who travelled 30 minutes or less to the clinic. Using a taxi or walking were found to be the most common means of transport used to gain access to such a clinic. The findings showed that generally, participants were satisfied with the services provided. Further it stated that long queue, lack of equipments, staff shortage, slow service delivery and negative attitude of health care staff were major constrain in utilization of CHCs. Participants of this study had access to the community health care centres in the Tshwane Region and there seems to be effective utilization by patients accessing them.

Krajewsk et al., (2009) have tried to determine whether or not there is a difference in access to emergency operative care between Canada and the United States. For this they took all patients diagnosed with acute appendicitis for the period 2001 to 2005 from the Canadian Institute for Health Information database and the US Nationwide Inpatient Sample. Severity of appendicitis was determined by ICD-9 codes. They further characterized the Patients by age, gender, insurance status, race, and socioeconomic status (SES; income) and used Univariate and multivariate analyses to determine the odds of appendiceal perforation at different levels of SES in each country. The results suggested that access to emergency operative care is related to SES in the United States, but not in Canada. This difference could result from the concern over the ability to pay medical bills or the lack of a stable relationship with a primary care provider that can occur outside of a universal health care system.

Devoe et al., (2007) study was designed to identify barriers faced by low-income parents when accessing health care for their children and how insurance status
affects their reporting of these barriers. For this, a mixed methods analysis was undertaken using 722 responses to an open-ended question on health care access. Result shows that families reported 3 major barriers: lack of insurance coverage, poor access to services, and unaffordable costs. Barriers to health care can be insurmountable for low-income families, even those with insurance coverage. Patients who do not seek care in a family’s medicine clinic are not necessarily getting their care elsewhere.

O’Donnell (2007) opined that effective health care interventions are underutilized in the developing world, and income related disparities in use are large. The evidence concerning the access problem is summarized and its demand side causes are identified. They have proposed broad strategies to tackle the access problem through changes in economic incentives. They argued that there is a need to go beyond the identification of broad strategies to the design and evaluation of specific policy measures. They concluded by saying that only through experimentation and evaluation one will learn what works in raising health care utilization, particularly among the poor in the developing world.

Manjumder .A (2006) has investigated the important research question in health sector whether characteristics in the demand-side economics of health care are changing or whether supply side have altered leading to a change in the appeal towards a particular type of care or sources of it. It was investigated by examining the pattern of utilisation of health care in India, and two other leading economics of Latin America and Africa, namely Brazil, and South Africa. It has focused on only service delivery from the point of view of utilisation of services recognising two distinguishable sources of care: public and private. It collected individual-level data files on ever-married women from Indian National Family Health Survey-2 (NFHS-2, 1998-99), Brazilian Demographic and Health Survey (BR3-DHS III, 1996), and South African Demographic and Health Survey (ZA3-DHS-III, 1998). Logit model was used to determine the variables highly influencing on the choice of health care provider. Almost similar results were found in case of all the three countries. Age, standard of living, education and caste are found as important demand side factors.
The article by **Kathuria and Sankar** (2005) analyzed the performance of the rural public health systems of 16 major States in India, using stochastic production frontier techniques and panel data for the period 1986-97. The result shows that States differ not only in capacity-building in terms of health infrastructure created, but also in efficiency in using these inputs. There is scope for health systems to re-orient their strategies in order to provide the best health in the most efficient way or at the lowest possible cost.

**Majumder .A. and Upadhyay .V.** (2004) have identified geographical factors, social structure, family characteristics, and quality of care as the main determinants of the utilisation of public health care services in their study. It revealed that as education increases people are likely to avoid public health facilities for reproductive health related services. The study points hence the appropriate measures are not taken to address the above problems, the primary health care system in India will lose its credibility even among poor rural people who are not in a position to attend private health care facilities.

**Purohit’s** (2004) study focused on the performance of healthcare sector in 15 major States in India. It was attempted through a comparative analysis of various parameters depicting availability of health services, their utilization and health outcomes. The analysis depicts the prevalence of considerable inequity favoring high income group of States, in terms of healthcare resources, per capita government expenditure on medical and public health, total number of hospitals and dispensaries, per capita availability of beds in hospitals and dispensaries and health manpower in rural and urban areas. It concludes that the availability of these parameters have an impact on utilization levels and health outcomes in these States.

**Banerjee et al.,** (2004) paper was a report on a survey conducted in rural Udaipur. It ends with unusual statement that in Udaipur the fraction of visits to a public facility is highest for the richest groups i.e., the rich have significantly more visits to a public facility than the poor and the rich group spends significantly larger fraction of their health expenditure on public facilities than do the poor.

**Nair et al.,** (2004) have identified the determinants of utilisation of subcentre services. A random sample of 247 subcentres from three out of 14 districts of Kerala
was investigated. Physical verification of the facilities was done in a subset of 90 subcentres and household surveys of 750 households were performed in the service areas of those subcentres. About 30 per cent of the beneficiaries utilized services of the subcentres during the reference period. The relationship of selected predictor variables on utilisation of the services was found out. The district in which a subcentre was physically present was found to be the most important correlate of its utilisation.

Srinivasan K. and Mohanty S.K (2004) explore the extent of household’s utilisation of curative health services from different sources such as public, private and other health practitioner at different levels of deprivation in India and major states, both for urban and rural areas. The variable on utilisation of health services from different sources has been analyzed using the data collected in the National Family Health Survey-2 by the International Institute for Population Sciences. The results of NFHS have compared with NSS 52nd round results. Both the data sources agreed broadly at the national level on the extent of private health care utilisation. Generally the extent of use of the public sources have been underestimated in the NSS or overestimated in the NFHS. With respect to government sources the urban estimates from the two sources are closer while the rural estimates differ at least by 10 percentage points. In all the states and across all economic strata, the public sector continues to be the major source for family planning services including in urban India. The findings of the study call for further focused studies on the public health system in the country for assessing the extent of use and reasons for non-use by different segments of the society.

Macinko et al., (2003) article critically reviewed the published literature on the relationship between income inequality and health outcomes. Studies are systematically assessed in terms of design, data quality, measures, health outcomes, and covariates analyzed. 33 studies indicate a significant association between income inequality and health outcomes, 12 studies do not find such an association due to some inconsistencies such as: (1) The model of health determinants is different in nearly every study; (2) Income inequality measures and data are inconsistent and; (3) Health outcomes differ etc. So, it suggests that future studies require more
comprehensive model of health product that includes health system covariates, sufficient sample size, and adjustment for inconsistencies in income inequality data.

The main objective of Mathiyazhagan’s (2003) study is to examine the people's choice of health care provider in rural India and the policy concerns it engenders. This is achieved through Logit Model by using the rural household survey on health in Karnataka state in India. The study also explores the Heuristic approach through observation and informal discussion with rural people about their opinion on existing health care services. The analysis shows that the private health care provider has emerged as the people's choice. However, the choice is significantly linked with socio-economic conditions of the rural people.

Bhatia and Cleland (2001) felt that understanding of health-care seeking behaviour- both in terms of utilization of different sources of care and expenses on treatment was important in the formulation of health policies and programmes. Therefore, they conducted a study on health care seeking behaviour and expenditure pattern by young Indian mothers both in public and private sector with special reference to Karnataka. The results have shown high dependence of health care seekers on private practitioners both in India and Karnataka and found marginal difference in the expenditure (visit cost) occurred on government and private practitioners. In case of place of residence the result shown that urban women spent much more money on consulting private practitioners and on self-medication compared with their rural counterparts. Further, it points out the need of improving the quality of care at government facilities to make them more affordable for poorer sections of society and at private medical sector as majority of care in India is provided by this sector.

Kutty’s paper (2000) assessed the factors associated with utilization and source of outpatient care in urban Kerala, and discussed policy implications with regard to access to health care. A multilevel analysis of individual and urban characteristics associated with utilization and source of outpatient care was conducted using data from a 1995–96 survey by the National Sample Survey Organization on health care in urban Kerala. The result shows that there is a high level of utilization (83.6%) of allopathic medical services. Controlling for illness severity and age,
utilization thereof was lower for the very poor, inhabitants of medium towns and inhabitants of cities with a lower proportion of permanent material (pucca) houses. Among all users, 77% resorted to private source of health care. Utilization of a private provider was less likely for the very poor and individuals from casual worker households while it was more likely for inhabitants of cities from both low public bed density districts and high private bed density districts. Problems of quality and accessibility of the public sector were invoked to justify utilization of private clinics. A marked heterogeneity in utilization of outpatient care was found between cities of various sizes and characteristics. Thus the study confirms high utilization of private outpatient care in Kerala and suggests problems of access for the poorest. Even in the context of high public health services availability and considering the health transition factor, relying on the development of the private sector to respond to increasing health care needs could create inequalities in access. Investing in the public urban primary care system and ensuring access to quality health care for the poorest is warranted.

Nemet and Bailey (2000) have explored the relationship between distance and the utilization of health care by a group of elderly residents in rural Vermont. The study devised a test to find the role of distance for utilization, and operationalizes this test using a custom designed survey. Using a randomized mail survey of elderly residents of Vermont’s North East Kingdom they explore how grocery shopping, travel to work, home location relative to local services, access to private transportation, and living arrangements are associated with the number of doctor visits made to primary health care providers. Although the results confirm the idea that increased distance from provider does reduce utilization, they strongly suggest that distance to provider is a surrogate for location in a richer web of relations between residents and their local communities. They concluded by calling for further research that establishes links between place and the use of health facilities.

The paper by Rajeshwari (1996) examines the spatial variations in gender bias in the use of public health care facilities in rural Haryana. It has taken such districts in the state which are the representative of low provision of health care infrastructure and high level of economic development on one side namely Kurukshetra, and on the other, district, which are economically backward but the provision of public health care infrastructure in maximum namely Bhiwani. The
results of the study revealed that the availability of public health care facilities at the
place of residence, overall economic development of an area and higher income of
families have important factors which contributes significantly in reducing the male –
female disparity in health service utilisation and positively impact on women’s health
status; Further, it identified a positive association between adult education standards
and proportion of persons treated with ailments. Thus, the study witnessed a decline
in sex disparity as one moves up from low education status to high education status.
In this background, the study has suggested the provision of public health care
facilities (HCFs) at the place of habitation coupled with increased educational status
or awareness towards various health care programmes in reducing the selected bias
against women.

Baru’s (1993) paper focused on the inter-regional differences of allopathic
health services provided by public, private and voluntary sectors within Andhra
Pradesh by taking two economically advanced and two backward districts. It pointed
that the growth of private nursing has been significant in the advanced districts with
the bed strength in the private sector double that of the number of beds in the public
sector.

Ghosh.B.N and Mukherjee.A.B (1989) have studied the service coverage of
primary health centres and service bottlenecks in West Bengal. It covered seven
hundred rural families from different socio-economic groups residing at different
distances from the primary health centre. It found that- (1) the families with higher
income utilized the primary health centre services least (4.1 percent), compared to
lower income families (17.7 percent);(2)utilisation of the primary health centre
services significantly declined with distance from the health centre;(3) distance from
PHC, and caste, education and income were the bottlenecks in PHC service utilisation
in West Bengal.

The study by Mwabu (1986) noticed that the observed visits to health care
providers are outcome of patients' health care decision-making process. Unlike the
visits, this process is not observable. The paper first outlined this process, and then
presents patterns of patients' visits to health care providers in a particular rural area in
Kenya. The visit patterns are shown to vary greatly according to type of illness and to
the stage of the illness. The paper has two main results. The first result is that in the study area, the majority of the patients sought medical treatment outside the ‘free’ government health care system. The other finding is that for a given illness episode, there is a very high likelihood of a patient consulting more than one provider for advice or treatment.

2.2.3. Reviews Relating to Service Quality Assessment

The reviews in this section are divided into two parts. The first part presented the reviews on the development of the concept SERVQUAL, a model popularly used to measure the service quality and its application in different service sector apart from health care. The second part presented the works which tried to assess the service quality in health sector.

I. Reviews relating to the concept of SERVQUAL and its application in different service sectors

Rekha and Jayasathya (2013) have explained the concept of SERVQUAL model propounded by Parasuraman et al., in service sector with five dimensions such as Tangibles, Reliability, Responsiveness, Assurance, and Empathy. They have called the SERQUAL model as popular and efficient measure of service quality.

The study by Jha et al., (2013) tried to measure the perceptions of customers’ relating to the image of company (corporate image). Corporate image (CI) in the study was measured with 5 items, interaction quality (IQ) with 5 items and customer satisfaction with 5 items by adopting different point of scales. The finding highlighted the importance and relevance of corporate image as a signal of unobservable quality, which should be measured and monitored by management and also the role of interaction quality in improving the customer perceptions on CI.

Sritharan .V (2013) has used SERVQUAL model with the objective to identify the dimensions of service quality of National Saving Banks (NSBs) in Northern Province in Sri Lanka. Data was collected with the technique of convenience sampling from 350 customers of NSB from Northern Province of Sri Lanka. Overall 24 service quality characteristics have been used in the study. Responses on the service quality dimensions were recorded using five-point Likert
scale, ranging from strongly agree (5) to strongly disagree (1). The results of the study were: (1) Correlation result clarified that, all the service quality dimensions such as reliability, responsiveness, assurance, empathy, tangible, and communication have a positive relationship with customer satisfaction; (2) Multiple regression model used to measure the impact of service quality dimension on customer satisfaction revealed that, almost 81.4% of the variations in customer satisfaction was explained by the above six dimensions and increase in the perception on all service quality dimension will increase the customer satisfaction and; (3) The significant ANOVA or F statistics at 5% alpha indicated that, the mean values of the total service quality of the NSB branches were not same for four grades of NSB branches.

Rahaman et al., (2011) have highlighted the importance of service quality gaps associated with external customer services in the banking services of the Bangladesh especially in Private Commercial Banks (PCBs) with the help of SERVQUAL model. They collected data on 20 service quality items along with other variables from 310 customers of 80 branches of 30 different PCBs in Dhaka city, using random sampling technique. They found that there is a gap between perceived services and clients’ expectation of services on PCBs and mainly reliability, responsiveness, and assurance dimension are crucial factors of determining service quality gaps in PCBs. Further, they pointed out how management of services can become more logical and integrated with respect to the prioritized service quality dimensions and their affections on increasing or decreasing service quality gaps.

Parasuraman .A et al., (1988) have briefly discussed the conceptualization and operationalization of the service quality construct, and developed 22-item instrument called SERVQUAL for assessing customer perceptions of service quality in service and retailing organizations after analysing of four independent samples such as bank, credit card company, repair & maintenance company and long-distance telephone company.

II. Reviews relating to the Health Care Service Quality Assessment:

Paper by Kovai et al., (2012) has addressed the issue of what determines patient satisfaction with primary eye care services through the concept of Vision Centers (VCs) in rural India. A total of 127 patients were interviewed from two VCs
at Easily Accessible Rural locations (ERL) and the two VCs at Remote Rural Locations (RRL) in Andhra Pradesh. Three factors such as Vision technician services, Location of VC, and Access to the services of VC respectively explained 61.5 percent cumulative variance of patient satisfaction. Three linear regression models predicted the association between patients’ characteristics and the three components of patients’ satisfaction.

Kumaraswamy (2012) has measured the service quality in corporate and non-corporate health care centres (HCCs). For this the health care organizations located at Madurai City, Tamilnadu were selected. In total, 100 patients who visited the two types of health care organizations during January-March 2007 were contacted for data collection. The analysis has revealed that: (1) the important service quality factors in health care centres are physician behaviour, supportive staff, atmospherics and operational performance; (2) The corporate HCCs are better rated by the patients than the non-corporate HCCs because of the Physician behaviour and Operational Performance at the Corporate HCCs and; (3) the important discriminating SQFs among the corporate and non-corporate HCCs are Atmospheric and Supportive staff.

Rao P.H (2012) has analysed the growth of private health sector in India with the help of data documented from planning commission, NFHS, NSSO and the studies conducted in different states like Maharashtra, Delhi, Haryana, Andhra Pradesh, Kerala, Gujarat, Bihar so on. He has tried theoretically to assess the quality of care (QoC) in private hospitals by sub dividing private health sector into 3 groups such as (1) private medical practitioner (PMPs), (2) For profit hospitals and (3) Not-for profit hospitals. Further, he made a detail discussion on the various factors which influences the QoC in the private health sector such as: (1) Inputs-education, competency building, funding; (2) Process- standards and guidelines, accreditation, medical tourism, health insurance, social franchising, public-private partnerships and; (3) Environment- regulations & controls has been made future directions with respect to improving QoC provided by PMPs and hospitals in order to improve the outcome along with the framework are provided. Finally, he concluded that the QoC offered by the private health care delivery system needs immediate attention and there is an urgent need for developing an effective mechanism to monitor the QoC in India.
Sekandi et al., (2011) have conducted a study with the objective to identify factors associated with general satisfaction among clients attending outpatient clinics in a referral hospital in Uganda. They collected 210 samples from cross-sectional exit survey of patients and caregivers in seven outpatient clinics at Mulago national referral and teaching hospital. They used overall satisfaction as a primary outcome; as a composite variable from the mean of the total score of three question items. Four dimensions such as provider’s technical competence, provider interpersonal skills, health facility environment and accessibility was used as secondary outcomes of the study. Overall 14 items were used to measure the quality of service. Techniques like linear regression, Pearson linear correlation coefficient were used in the study. The results pointed out that patients’ perceptions of provider technical competence and accessibility of services were positively associated with general satisfaction. The sub-optimal satisfaction scores for outpatient care strongly suggested key factors such as category of clinic visited, waiting time, costs incurred, accessibility of service and provider’s technical competence should be addressed to improve the quality of service delivery at Mulago hospital.

Sohrabi et al., (2011) assessed clients’ satisfaction with primary health care in Tehran, the capital of Iran, a metropolitan city. A cross-sectional study was conducted in 2009-10, 4 urban primary health care clinics were selected through stratified random sampling. Overall 400 participants were interviewed in selected clinics based on convenient sampling method. Data was collected on six domains of satisfaction such as: accessibility of services (8 items), continuity of care (6 items), humaneness of staff (8 items), comprehensiveness of care (5 items), provision of health education (5 items) and effectiveness of services (10 items). Each item in six domains was measured on a five-point Likert scale. The results showed that all the six domains needed more attention to provide an effective health services in Tehran. High overall satisfaction with primary health care was considered as a key measure for assessment of the quality of health services and predictor of compliance and utilization.

The article by Prakash B. (2010) focused on patient satisfaction, its assessment, and its effects on health care delivery, particularly with reference to dermatological and esthetic practice. It suggested that to improve the patients’ satisfaction (measure of quality service) minimum requirements and standards have to
be maintained in telephone service, office appearance, waiting time, doctor-patients interaction, and problem solving.

**Hansen et al.,** (2008) have tried to develop a scale to measure client perceptions of quality, and assess its reliability and validity, and identified the factors associated with client quality perception in Afghanistan. For this they did a cross-sectional survey of outpatient’s health facilities, health workers, patients and caretakers. A scale of client perceptions of service quality was developed from eight items measured in Likert four-point scale such as- the health unit is clean, the health staff are courteous and respectful, you trust in the skills and abilities of the health workers, the health workers did a good job of explain the illness, the health workers did a good job of explaining the treatment, it is easy to get medicines that health workers prescribe, the cost of this visit to the health unit was reasonable and you had enough privacy during the visit. Facility type is included to determine whether client perceived quality varies by level of the primary care system. To develop the perceived quality scale, Principle Component Analysis (PCA) and Maximum Likelihood Factor Analysis were conducted. Multiple linear regression models were used to compare differences in levels of perceived quality across groups. Clients of primary care services in Afghanistan reported relatively high levels of perceived quality. Most of the variation in client perceptions quality that is explained by the models relates to the patients interaction with the health workers and not to health facility characteristics, such as cleanliness, infrastructure, service capacity and the presence of equipment or drugs.

The study by **Çaha .H** (2007) has used dynamic model to determine the service quality of private hospitals and the consumer satisfaction in Istanbul, Turkey. A version of model developed by Kara (2000) was used in the study. The patients who hospitalized at the specific ward for at least 3 days and mentally stable were considered for the interview, thus a total of 400 patients were interviewed from four B category private hospitals. Along with 34 Service Quality items, 3 other general questions were covered in the study. The results indicated that satisfaction of the patients is the most important factor for the private health care providers, as the patients have alternative hospital choices. The main reasons behind the quality of private hospitals service were identified as lack of physical and human capacities.
Andaleeb et al., (2007) has attempted to identify the determinants of patient satisfaction with public, private and foreign hospitals. A survey was conducted involving inpatients in public and private hospitals in Dhaka city, Bangladesh and patients who have experienced hospital services in a foreign country. Views from patients were obtained through exit polls using probability (for public and private hospital patients) and non-probability (snowball sampling method applied for foreign hospital patients) sampling procedures. A total of 413 samples were collected, 13 were dropped due to excessive missing data. Descriptive statistics indicated that foreign hospitals were rated highest on all service dimensions. Service orientation of doctors has come out as the strongest factor influencing patient satisfaction in all three types of hospitals.

Taner and Antony (2006) have applied the principles behind the SERQUAL model to examine the differences in service quality between public and private hospitals in Turkey. In this process a total of 200 outpatients were interviewed on 40 service quality indicators on expectations and 40 on perceptions, using Likert-type scale. The three major findings of the study were: (1) Inpatients in the private hospitals were more satisfied with service quality than those in the public hospitals; (2) Inpatients in the private hospitals were more satisfied with doctors, nurses and supportive services than their counterparts in the public hospitals and; (3) Satisfaction with the doctors and reasonable costs were the biggest determinants of service quality in the public hospitals.

Mathiyazhagan’s (2006) paper analyzed the cost efficiency of public and private hospitals in Karnataka State in India, through parametric and nonparametric methods by using the Hospitals Facility Survey (2004) in Karnataka State. It has used the stochastic frontier cost function for estimating overall cost efficiency along with Data Envelopment Analysis (DEA). The findings indicated that, the choice of econometric approach did not make any significant difference in the results and they are robust. Further, it emphases that there is a need to maintain the quality of healthcare services both in public and private hospitals under the emerging competitive environment; otherwise, it would be subject to financial vulnerability since private hospitals highly depend on the user fee payment of the patients in the State.
Rao et al., (2006) developed a reliable and valid scale to measure in-patient and out-patient perceptions of quality in India and identified aspects of perceived quality which have large effects on patient satisfaction. A cross-sectional survey of health facilities and patients at district hospitals, community health centres, and primary health centres’ in the north Indian state of Uttar Pradesh was conducted. Five dimensions of perceived quality was identified- medicine availability (2 items), medical information (3 items), staff behaviour (2 items), doctor behaviour (5 items), and hospital infrastructure (4 items). Multivariate regression analysis results indicated that for out-patients general patient satisfaction is largely effected by doctor behaviour followed by medicine availability, hospital infrastructure, staff behaviour, and medical information. On the other hand for in-patients they are doctor behaviour, medicine availability, medical information, and hospital infrastructure. Thus in both the cases, the interpersonal skill of the medical personnel and availability of medicine accounted large influence on patient satisfaction.

Rohini and Mahadevappa (2006) presented a service quality perception undertaken in five hospitals located in Bangalore city. SERVQUAL questionnaire was used for the measurement of gaps. An analysis covering a sample of 500 patients revealed that there exists an overall service quality gap between patients’ perception and their expectations. On the other hand, an analysis covering a sample of 40 management personnel revealed that a gap also exists between managements’ perception about patients’ expectations and patients’ expectations of service quality. Finally, it suggested improvements across all the five dimensions of service quality such as- tangibles, reliability, responsiveness, assurance and empathy.

The study conducted by Tuan et al., (2005) in Vietnam gave surprising result. They pointed that in rural Vietnam public sector health infrastructure was superior to the private providers and the quality of services provided by public providers was poor but significantly better than that of private providers. Interestingly patient satisfaction and costs of care were found similar between the two groups. Further, it has supported the previously observed phenomena of high levels of self-medication, low utilisation of commune health centres and over-utilisation of tertiary health care facilities was due to the low quality of health care services at a community level in Hung Yen.
Chahal et al., (2004) have analysed the factors affecting patient satisfaction in public health care outpatient services. They measured patient satisfaction with respect to technical and non-technical characteristics of health care service encounters, categorised into four basic components such as: attitude towards doctors, attitude towards medical assistants, quality of administration and quality of atmospherics. The degree of consumer satisfaction was measured through the five-point scale. Finally, they concluded that strategic actions are necessary for meeting the needs of patients of the public health care sector in developing countries.

As patient satisfaction is an important measure of service quality in health care systems, Yildrız Z. and Erdogmus S. (2004) study has developed a reliable and valid instrument to measure patient satisfaction in Turkey by interviewing the 1100 patients in 31 different hospitals.

Lim et al., (2004) have presented the findings of a United Nations development programme- WHO study commissioned by China’s ministry of Health on use of public and private ambulatory care services in three Chinese provinces which are in different stage of economic development. The major results of the study were as follows: (1) out of 3730, 71 percent respondents reported having no health insurance of any kind and the percentage of uninsured was found much higher among rural (90 percent) than urban residents (51 percent); (2) Multivariate analysis using Cox regression model has revealed that health care use (both public and private) has been independently influenced by a number of factors such as: health status, sex, province, household income, residence, and health insurance; (3) 16 percent of the total sample residents reported to have not entered the health care system at all for the entire year, despite having felt a need to do so. The major reason cited for this was cost (49 percent) and; (4) The people who visited private clinic reported higher overall satisfaction levels and better health status than who visited a public clinics and private patients gave consistently higher ratings than public patients for eighteen of twenty-one items. Thus, the private sector outperformed the public sector in the survey of patient satisfaction in China. The study concluded that widespread dissatisfaction with public providers mainly in high user fees and poor staff attitudes has driving patients in China to seek cheaper but lower-quality care from poorly regulated private providers.
Aldana et al., (2001) study showed that patients accessing maternal care services were significantly more dissatisfied (37.6%) than clients accessing other types of services in rural Bangladesh. Satisfaction with the provider’s usual behaviour was expressed by 68.9% of patients, which indicated importance of provider’s behaviour in patient’s satisfaction, particularly respect and politeness of providers towards patients. Multivariate analysis revealed that length of waiting time is negatively associated with the patient’s overall satisfaction.

Study by Andaleeb (2000) compared the quality of services provided by public and private hospitals in Bangladesh. It has made a premise that the quality of hospital services was contingent on the incentive structure under which the institutions operate. Since private hospitals are not subsidized and depend on income from clients, they are motivated than public hospitals to provide quality of services to patients to meet their needs effectively and efficiently. MANOVA results supported the premise of the study. Further, the discriminant function identified discipline, responsiveness, and income as the three most important factors that accounted for the type of hospital chosen.

Sharma and Chahal (1999) have constructed a special instrument for measuring patient satisfaction with diagnostic services in Jammu, India. The instrument has captured the behaviour of doctors and medical assistants, quality of administration, and atmospherics. Patient’s satisfaction was quantified by measuring the attitude of regular and experienced patients and assumed that these patients have formed a positive attitude with regard to the service performance of the provider based on the prior use of services. A five-point Likert scale ranging from strongly agree (5) to strongly disagree (1) was used for each statement (108 items). Data was collected from 220 randomly selected patients of three reputed private health care units in Jammu city. The results of the study were: (1) Knowledge and efficiency were found as the most important attributes with first rank; (2) Attributes like grievance handling system, invitation of suggestions and their implementation contributed less to the patient satisfaction score and; (3) Behaviour of doctors and medical assistants emerged as the important predictors of overall patient satisfaction.
Khot A. and Menon S. (1999) attempted to highlight certain key issues, which need to be dealt with and are essential for a new beginning in the quality movement in health care delivery. And, they considered accreditation as an appropriate approach towards ensuring quality of health care.

Donabedian (1997) has in detail explained the steps to be taken to assess the quality of care in health sector and also the levels at which quality can be assessed. He classified the quality of care into three categories: (1) Structure- this includes the attributes of material resources (such as facilities, equipment, and money), of human resources (the number and qualification of personnel), and of organizational structure (medical staff organization, methods of peer review, and methods of reimbursement); (2) Process- patients' activities in seeking care and carrying it out as well as practitioners' activities in making a diagnosis and recommending or implementing treatment and; (3) Outcome- degree of the patients satisfaction with care.

Based on the theoretical works on SERQUAL instruments, Vandamme and Leunis (1993) made an empirical study in a Belgian hospital and tried to develop an appropriate multiple-item scale to measure hospital service quality. They discussed discrepancies between SERQUAL and the dimensions, along with the reliability and validity properties of the scale and critically commented on the SERQUAL approach with recommendations for future research.

Babakus and Mangold (1992) have empirically evaluated the potential usefulness of SERVQUAL model (a comprehensive service quality measurement scale) propounded by Parasuraman et al., in a hospital service environment. A midsized hospital, located in the southern part of the United States was considered for the study. Responses on 15 pairs of matching expectation/perception items, representing all five dimensions of service quality listed by Parasuraman et al., (1988) were collected in five-point Likert format instead of original seven-point scale format and using uni-dimensional measure. The results were strongly supported the application of SERVQUAL model to hospital service environment and also exhibited the need for further work on the dimensionality and abstraction level of the construct.

To identify the dimensions of patient satisfaction questionnaire and determinants of patient satisfaction Abramowitz et al., (1987) have conducted a
telephone survey of 9 percent of first quarter discharges at the New York Hospital by incorporating 10 aspects of service along with overall satisfaction with hospital services. The best determinants of overall satisfaction with hospital care appeared as patient expectations and satisfaction with nursing care.

The above review of literature throws light on following facts:

- The studies on health expenditure show the existence of wide regional disparity in health care expenditure irrespective of countries which in turn create vast disparities in health outcomes between regions.
- In India the health policy has shifted its focus from a comprehensive universal healthcare system to a selective and targeted programme based healthcare policy with the public domain being confined to family planning, immunization, selected disease surveillance and medical education and research.
- The studies on Indian health services indicate that the health service in India is in bad shape and the withdrawal of government from the service sector has led to the presence of private enterprises and corporate bodies and emerge as major health service providers both in rural and urban India at all levels of care.
- The decline of public investments and expenditures in the health sector since 1992 has weakened the public health sector in India, adversely affecting the poor and other vulnerable sections of the society.
- Studies relating to health care service utilisation indicate that the health facilities are unequally distributed between rural and urban areas and although it confirms that along with availability of facilities, utilisation of health care service is influenced by a number of supply side and demand side factors such as age, caste, distance, income, education, place of residence, sex, transport facility, availability of medical personnel, attitude of staff, waiting time, infrastructure and satisfaction from services. They are considered as major driving factors in the choice of health care providers.
- Increase in the population, rising socio-economic status (increase in income and education) and exposure to international standards of quality have led to increasing demand for quality health care both in public and private sector.
The literature confirms that the SERVQUAL model is a popular and effective service quality measure in all service sectors.

Studies on quality assessment of health care services shows that patient satisfaction is a key criterion to evaluate the quality of health care services and patient judgement of hospital service quality and their feedback are found essential in quality of care monitoring and improvement.

Public and private hospitals significantly differ in many service qualities such as discipline, responsiveness, physician behaviour and so on.

The above mentioned facts prove to be beneficial in identifying the research gaps, on which the objectives of the present study are based on. It is clear that no studies that have tried to compare public and private health sector on the issues of availability of health facilities, utilisation of health services in rural and urban areas, and service quality together in Karnataka. Therefore, the present study attempted to comparatively analyze availability of health facilities, utilisation of health facility and the quality of service in private and public health sector. Further, the comparison is also extended to rural and urban areas.