ABSTRACT

The whole conceptualization of this research topic was a by-product of personal experiences at some of the Government and the so-called Charitable Hospitals. Having taken the gauntlet there was no option of going back in spite of the warnings by friends, specialists like Mr. Barnes of CRMGuru fame and the lack of research in this area.

Healthcare marketing primarily being a service marketing concept, Relationships are very important. Relationship Marketing is a marketing method in which businesses consistently maintain two-way communication with their prospective, current and inactive customers in order to gain a deeper understanding of their needs while delivering personal and compelling marketing throughout their lifecycle.

Managing Profitable Customer Relationships will be a key success factor for most Indian Companies as we move into the 21st century. However, many Companies are taking pre-mature decisions of starting 'loyalty or frequency' programs for their customers. Since Relationship Marketing requires a considerable investment of time, talent and rupees, it's vital that we take care to avoid some of the pitfalls we may encounter on the road to a successful Relationship Marketing Program (Sethi 2002).

Research in relationship behavior and relationship marketing has presented a lot of strong evidence that supports the hypothesis that the relationship aspect plays a central role in the understanding of markets and company behavior in real life. This research not only draws such conclusions from empirical evidence, but also from theoretical models of behavior and marketing systems that can actually describe and explain relationship patterns and market structures (Hougaard and Bjerre 2004 14).

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Given the dramatic effect that improved customer retention can have on business profitability, the hospitals need an approach that leads to greater loyalty, enhanced relation and profitability. This in turn requires them to better understand how to measure customer retention; identification of root causes of defection and related key service issues; and the development of corrective action to improve retention. The Healthcare Sector broadly comprises of: Hospitals, Medical Tourism, Health and Health Management Education, Health insurance, Laboratory and Diagnostic Services, Pharmaceuticals & Drugs Segment, Medical Devices and Equipment, Registries, Healthcare BPO, Telemedicine, Immunology, and Managed Care. We are restricting this study to Hospitals only.

The setting up of the Corporate Hospitals, although still at the nascent stage in India, was preceded by the Charitable Hospitals phase. The healthcare scenario had otherwise been occupied wholly by the Government Sector except for the private clinics. Now, the situation has reversed wherein the Government investments in the Hospitals is very less, barely to the extent of 20% of the total expenditure on health in India. Although, on the whole for an Asian comparison the Health expenditure as % of GDP for India is a healthy 5% + and is only second to China.

In India healthcare is about to explode: the sector, comprising sectors like hospitals, health insurance, and managed care is worth $15 billion translating to Rs. 670 billion currently (that's almost equal to the turnover of the country's 12 largest private sector companies including Reliance Industries, Hindustan Lever and ITC). But that's just the tease. "The real McCoy, lies in the fact that India's healthcare sector is expected to grow by around 13 percent a year for the next five years", said Amit Bagaria of Asian Health Services (Medserv website article). India with its inherent qualities can become the global hub for healthcare services. It is being touted as the next 'big boom' and the sector is expected to grow rapidly over the next decade, to reach a level of Rs. 3200 billion by 2012,
largely spurred by an increased corporate presence in the sector. The need of the hour is to understand this market and plan future strategies to harness the lying opportunity (Industry Insight 2006). The windfall began ever since the developed world discovered that it could get quality service for less than half the price.

- In the last five years, the number of patients visiting India for medical treatment has risen from 10,000 to about 100,000. According to Apollo group chairman Prathap Reddy, one out of every ten patients treated at his hospitals is from abroad.
- With an annual growth rate of 30 percent, India is already inching closer to Singapore, an established medicare hub that attracts 150,000 medical tourists a year.
- Hospitals in India boast of conducting the latest surgeries at a very low cost.
- India’s independent credit rating agency CRISIL has assigned a grade A rating to super specialty hospitals like Escorts and multi specialty hospitals like Apollo.
- NHS of the UK has indicated that India is a favored destination for surgeries.

The Indian healthcare industry seems to have come a full circle — moving from rural to urban areas and now back to small places, offering an unprecedented pace, scale and spectrum of services. The development, of course, was inevitable, given the geographical advantage, talent pool, enterprise level and growth potential in the country. Arguably, the decade gone by was a crucial differentiator in the healthcare scenario.

The private Indian healthcare sector has the following major corporate players:

- Apollo Group of Hospitals
- Fortis Healthcare includes Escorts
- Max Healthcare
- Wockhardt Hospitals Ltd.
- Birla Heart & Research Centre
In spite of the reforms sweeping the healthcare sector in general, the Indian hospitals are constrained by several government regulations. To begin with, Indian hospitals are not allowed to advertise the way a telecom service marketer or a consumer goods marketer would. When millions of rupees in technology and infrastructure are invested in a hospital, it makes it less than fair. It impacts their efforts to survive, attract patients and to generate funds though deregulated marketing, they contend. Still, each corporate hospital has formulated its differentiated marketing strategy and business development plans to benefit from the opportunities and to relate better with their customers.

The relevance of the research is both from industry and academic viewpoints. The objectives of this research are:

- To ascertain the Customer Service Quality perceptions vis-à-vis the expectations.

The research sub objectives to attain the main objective are:

- To understand the service standards maintenance thru responsiveness, reliability and assurance.
- To understand the convenience, empathy and tangibles delivery against the expectations.

This study is descriptive in nature and IS conducted in phases. The first phase deals with developing an appropriate research framework with facts and theories accessed from literature survey on Healthcare sector, Healthcare sector Analysis, and the current pattern of Customer Relation practices in the Healthcare sector. The aim is to develop the framework, which will then be used to serve meeting the research objective and sub objectives.

The second phase of the study is an empirical study of Hospitals through the beneficiaries. The research approach would be Survey Research, through
structured questionnaire and Interviews. The standardized and validated questionnaire after due pilot testing and suitable changes, if any, will be used for this.

This study is limited in its approach. The retention strategies are being examined only in the context of Healthcare Sector with specific focus on corporate hospitals and their customers out of a total of numerous Hospitals in India spread across different geographical locations. While all the corporate hospitals in Delhi have been attended to personally for the questionnaire administration, some randomly chosen hospitals were sent the questionnaires by mail to seek the responses.

Yet the study is likely to contribute to the newly developing field of research on managing customer relationships, as issues are examined critically in the context of emerging Healthcare scenario. This will immensely help the Healthcare sector in integration of right attitudes with service delivery and customer relationships endeavors so as to take more and more market shares and hence profits. The Study will evoke scope for further research in this emerging field for ultimate benefit of society at large.

The research also discusses the theoretical aspects of CRM in its various forms, namely:

- Caring Relations Management (CRM)
- Continuous Relations Management (CRM)
- Creative Relations Management (CRM)
- Customer Retention Management (CRM)
- Customer Return Management (CRM)
- Cost Reduction Management (CRM)
- Cost and Return Management (CRM)

Customer lifetime value has intuitive appeal as a marketing metric, because in theory it allows companies to know exactly how much each customer is worth in
dollar terms, and therefore exactly how much a marketing department should be willing to spend to acquire each customer. In reality, it is often difficult to make such calculations, either due to the complexity of the calculations, or to the lack of reliable input data, or both.

In more ways than one, CRM represents a logical end of the philosophy that the business should be customer oriented (Gamble, Stone and Woodcock 2000; Payne 1997). It traversed the successive strains of thoughts to reach what is now viewed as a new business paradigm. For instance, the early marketing paradigms prevalent until the sixties, ordained marketers to satisfy customer needs that were essentially nature created. Later in the seventies, the marketing functions served the customer wants that were nothing but ‘specific solutions’ to the needs and were the outcome of the marketing initiatives. Marketing thoughts of the eighties devoted themselves to meet the higher, more lifestyle oriented demands and expectations of customers. These were the result of the then social and economic environment. The nineties witnessed the most potent force of our times, information technology. Naturally marketing thoughts focused on how to leverage on the same and serve the customers (Kotler, 2000). One of the fall out of the era is Customer relationship management. CRM, thus, represents ‘the marriage between the customer orientation and the emerging information technology to produce a memorable relationship experience to the marketers as well as to the customers (Agrawal 2002).

• The Indian CRM market can be sized at Rs. 50 -100 Crores (1Crore=10 million)
• The CRM market can be segmented into the market for software and services
• The services segment includes outsourced CRM services, integration, training, and consultancy.
• The market for CRM services is considerably larger than the market for CRM software.
The literature review and the theoretical aspects in the discussion also include details about the

- Indian Healthcare Sector.
- The existing Major Indian Corporate Hospitals.
- International Hospitals entering or planning to enter the Indian market.
- Soft nuances of the healthcare sector e.g. Marketing, Hospital Architecture, Hospital Consultancy Services, Accreditation, Mergers and Acquisitions, Patient Grievance cell, and Medical Tourism.

The core of the study is formed by the Research Methodology and the Analysis parts. The problem here is identified in terms of the customer satisfaction.

*Are the hospitals doing enough to keep the patients/customers happy and satisfied? Is it important?*

Our basic research design process is Descriptive. Further the study is cross sectional in nature employing a correlation/paired comparison research design to describe the statistical association between two or more variables.

The most major type of information utilized by us is primary data. This is done thru one on one interview at the place of discussion i.e., the hospital itself, both inpatients as also the outpatients.

The literature review is a secondary data type. The sources have been books, periodicals, websites, printed literature from the hospitals etc.

The survey research methods have been employed for accessing the primary data. This has been taken care of thru designing of the Questionnaire and self-administered: face to face interviews. Questionnaires were also sent to outstations for responses from all over India.
The secondary data is taken from newspapers, books, periodicals, internet search, printed literature from the hospitals, and stock exchange reports etc.

A structured questionnaire was developed to collect data on the variables in this study. The questionnaire was adapted from the famed Service Quality: SERVQUAL (Parasuraman, Zeithaml, and Berry 1986, 1988); Ethics: Corporate Ethics Scale: CEP (Hunt, Wood, and Chonko 1989); Ethics: Marketing Norms Ethics Scale (Vitell, Rallapalli and Singhapakdi 1993) and Customer Orientation (Deshpande, Farley, and Webster 1993). A modified SERVQUAL questionnaire relevant to the healthcare industry was constructed by including items from the original five dimensions (Tangibles, Reliability, Responsiveness, Empathy and Assurance) of the SERVQUAL instrument developed and updated by (Parasuraman, Zeithaml, and Berry 1986, 1988). Cronin and Taylor (1992) test several service quality models, as well as the relationships among service quality, satisfaction, attitude, and purchase intentions. Their research supports measuring service quality as a unidimensional, performance-based construct called SERVPERF, which is equivalent to the 22 PERCEPTION items of the original SERVQUAL measure.

The items were refined and paraphrased in both wording and contextual application as appropriate to suit research purposes. Next, in order to obtain an even more comprehensive and industry-specific measure of the service quality construct, the research based upon the healthcare sector was undertaken. The instrument used for the Pilot study is attached in Appendix A.

The respective scales were used for the pilot so as to get the feedback on all the parameters i.e., Expectations and Perceptions, Ethics, and Customer Orientation. The pilot was administered to 50 respondents in total. The one on one interviews brought out some of the shortcomings clearly. The same are listed below:

- The questions were more Americanized and less pertinent in the Indian markets.
Some Indian features in terms of what Indian patients look forward to, were altogether missing.

Customer orientation, ethics scale and CEP questions were very direct while the questions from SERVQUAL were subtle and gentle and could get the desired inputs.

It was very difficult to cater to so many cross sections.

The feedbacks from Hospital staff were either strictly toeing the hospital line or were vitriolic against the Hospital Management. While the Doctors were 100% positive about the hospital the support staff was not.

The respondents’ suggestions were better tuned to a single questionnaire.

The comments and the observations from the pilot led to:

- A single common questionnaire with questions from the different questionnaires merged for the patients.
- Addition of many questions about access, water, telephone services, pricing, ethics etc.
- Deletion of some questions which were either not very pertinent to Indian public or they were not aware of.
- The Likert scale with the legend was placed at a conspicuous place to aid the respondents.
- The questionnaire was administered to same person for getting coherent responses against perceptions vis-à-vis the expectations hence, catering to a before after kind of a dichotomous relationship.

The duly tested and finalized Questionnaire is displayed as Appendix B. All the Questionnaire questions were close ended except for the demographic profiling questions.
The first section of the instrument consisted of forced-choice questions about demographic characteristics: age, gender, inpatient/outpatient, and urban/rural status while the questions on Income, ailment, education, age and the hospital name were open-ended.

All the patients visiting Corporate Hospitals as inpatients or outpatients in India form the population of this study. The charitable hospitals have been kept out of the scope of this study. The Universe or the population is thus the names of the patients registered with the respective corporate hospitals.

The population for this study as stated above is scattered all around India registered with one or the other corporate hospital. An all India study was, therefore, not feasible. The industry leaders and academicians were consulted so as to get a truly representative sample so as to avoid the biases. The number of corporate hospitals in India is not huge but the branches of different groups are many. In order to make it a representative sample the following hospitals were considered for narrowing down.

- Apollo Hospitals
- Escorts Hospitals
- Fortis Hospitals
- Max Hospitals
- Tata Hospitals
- Wockhardt Hospital

Although, subsequent upon the merger of Escorts Hospitals with Fortis Hospitals the two units are from the same group, yet they retain super specialized character in that the Escorts Heart Hospital caters only to Cardiac care. Tata has no presence in North India. Questionnaires were sent to Tata, Mumbai and Wockhardt, Mumbai by courier. The following was thus the sampling frame for our study – including all the Inpatient as also the out patients:

- Escorts Heart Institute and Research Centre, Delhi
- Fortis Jessa Ram Hospital, Delhi
Sampling unit for this study is the Corporate Hospital patient of the abovementioned Hospitals be it inpatient or outpatient.

Assuming the highest variability of 50% and designing for a ± 5% Sample error at 95 percent level of confidence the number of respondents required is 384 (Burns and Bush 2003: 392). We have taken a sample size of 500 out of which 404 questionnaires were administered personally while 100 were sent by courier to Tata Memorial Hospital and Wockhardt Hospital, Mumbai. The questionnaires were to be got filled by the hospital from their patients. The response rate against the direct mail respondents was a poor 2% and therefore the total sample size came to 406. Hence the number of the samples is sufficient to cater even the worst case scenario of 50% variability (in terms of the largest sample size).

The target population for the patients’ study consisted of healthcare service users at the six listed hospitals in Delhi and NCR and two at Mumbai. There being no published list or public domain or directory of corporate healthcare patients the survey was based on the random visit at random times to the Delhi Hospitals for interaction with randomly chosen patients without any bias or judgment. The study was also undertaken at the respective hospitals at different times to further minimize the bias. The Mumbai segment was covered through mailed questionnaires.
At the pilot stage as also during the actual survey stage, the questionnaires were filled by interviewing them personally. However, some questionnaires were sent by mail. The final realized sample included a total of 406 usable questionnaires, representing 79.60% success rate primarily due to near 100% success rate with the personal interviews.

The questionnaire was pre-tested using a convenience sample of approximately 50 respondents. Final data was collected over a period of three months. The study included a variety of respondents, like both genders, rural/urban, inpatients/outpatients to minimize any bias.

We have used Stratified Random Sampling in the said hospitals by taking randomly equal (nearly) number of respondents so as to study any relationships between the two. 216 outpatients were interviewed while 190 inpatients were the random respondents cutting across various illnesses, genders and other demographic details. The data was collected on the Questionnaires personally to minimize the nonsampling errors. The questionnaires were not got filled up from the non interested or “much in a hurry” respondents.

The reliability of the data was ascertained before any analysis was taken up so as to make sure about its utility for analysis. In this research, the multi-item scales measuring expectations and perceptions of the patients were checked for reliability by determining Cronbach’s alpha and an alpha value of 0.60 or greater was considered acceptable. The validity of a measurement instrument refers to how well it captures what it is designed to measure (Rosenthal & Rosnow, 1984).

In the case of the Expectations instrument the alpha value is in excess of 0.90 without an exception. Similarly the alpha value for each of the 32 variables in the Perceptions instrument is above 0.90. The Standardized item alpha = 0.9101 for the Expectations questionnaire and the value of Standardized item alpha = 0.9254 for the Perceptions questionnaire. This establishes the reliability and
validity of the instrument without any doubt and hence no fine tuning or changes in the Instruments are required.

This was followed by a demographic analysis of the sample. The sample is almost perfectly balanced in terms of Gender and inpatients/outpatients although there is a minor skew of 3% towards outpatients. The gender representation from urban populace is equally divided while females form less than 34 percent of the rural sample. Likewise less than 34 percent of rural sample were inpatients.

The sample is predominantly Urban (87.4 percent). Illiterates form the smallest mass and surprisingly the data is not too much skewed against the rural areas. The rural representation being miniscule not much meaning can be drawn from the sample, although the rural representation in the corporate hospitals may itself be very small indeed. Almost 30 percent patients from the rural areas were undergraduates while other 40 percent were Secondary school qualified. In case of the urban respondents more than 40 percent were undergraduates, 23 percent were with secondary education, and more than 20 percent were Postgraduates.

More than 72 percent Fortis Jessa Ram Hospital sample patients were females and hence homemakers formed the largest mass. In the other hospitals the proportion was rather even. The attendance of Service class people was rather even across the hospitals. 67 percent of females were homemakers while 50 percent of males were in service. 25 percent of the males were in business. Higher percentage of females was suffering from general, other, neurological and ENT ailments. The males were suffering more frequently with Cardiological, liver and orthopedic ailments.

While Escorts Hospital, Indraprastha Apollo Hospital and Max Devki Devi Hospital had majority of Inpatients in case of Modi Hospital, Fortis Jessa Ram Hospital and Pushpawati Singhania Hospital the converse has been true. The
rural attendance was the highest at Indraprastha Apollo Hospital. On the contrary the urban representation was the highest at Max Devki Devi Hospital.

The Hospitals attracted most patients from their respective super specializations, e.g., Escorts, Max and Apollo for Cardiology; Pushpawati for Renal, hepatic and Stomach; and Fortis, Modi for General patients (mostly outpatients). More than 60 percent inpatients were cardiology cases while majority of outpatients were from general or other ailments.

There is a KMO statistic for each individual variable, and their sum is the KMO overall statistic. KMO varies from 0 to 1.0 and KMO overall should be .60 or higher to proceed with factor analysis. If it is not, drop the indicator variables with the lowest individual KMO statistic values, until KMO overall rises above .60.

http://www2.chass.ncsu.edu/garson/pa765/factor.htm#kmo

If visual inspection of correlation matrix reveals substantial number of correlations greater than .30, then factor analysis is appropriate (Hair, Anderson, Tatham, and Black, 1998).

The correlation coefficients are all in the significant zone at 99% confidence level and hence ready for Factor analysis and such further studies. We also observe here that most of the correlations are above 0.300, the Factor Analysis is in order.

The t-tests, ANOVA, factor analysis, reliability analysis and reliability analysis helped the data analysis and the results are generalized as follows:

The corporate hospitals are not meeting the standards as expected by the patients on all the Factors although, by varying degree.

The Service Performance being not upto the Service Quality levels desired by the patients, the hospitals have got to get their act together. The Corporate Hospitals
must act in all the seriousness to plug the gaps and excel on the respective parameters.

The following is the hospital comparison in terms of the analysis of the collected information:

**BEST**
- Escorts Heart Institute and Research Centre is the best in terms of Tangibility, Convenience and Responsiveness implying that it has the least of difference between the expectations and perceptions.
- Indraprastha Apollo Hospital is the best in Assurance, Empathy and Reliability attributes.
- The Highest of the values all across the perception and expectation values across the factors is for Tangibility at Escorts.
- The Second Highest value all across the perception and expectation values across the factors is for Convenience at Escorts.
- The best performance is exhibited for Convenience and Tangibility.

**WORST**
- Fortis Jessa Ram Hospital is the worst in Responsiveness and Empathy.
- Pushpawati Singhania Hospital is the worst in Assurance.
- Max Devki Devi Hospital is the worst in Tangibility.
- Modi Hospital is the worst in Reliability and Convenience.
- The poorest performance is exhibited in Responsiveness and Reliability.

- The Lowest value across the factors is for Reliability at Modi Hospital.
- Second Lowest value across the factors is for Responsiveness at Fortis Jessa Ram Hospital.
Hence the Competitive advantage can be gained and further improved upon by Escorts Heart Institute and Research Centre and Indraprastha Apollo Hospital while furthering their performance for the other factors. Fortis Jessa Ram Hospital and Modi Hospital have considerable efforts to put in even to close their gap with Escorts and Apollo. Singhania Hospital and Max Hospital are more middle of the road hospitals and require lesser strategy and plans to catch up with the top hospitals.

India's corporate hospitals need to be fully equipped, up market and efficient. With their toll-free helplines, interactive websites, online quotes and time-bound treatment access, they can appear to be a world apart from the overburdened, often badly managed and poorly funded public health system. Although, it is a big question if all this will make the facilities unaffordable and out of bounds, in terms of waiting time, for the domestic population. Yet, one thing is for sure that the positive rub-offs will exceed the limitations and healthcare will become an effective and steadily growing sector with attraction of market entry for other players or for expansion of the network.

V.V. Bashi of MIOT Hospital, Chennai says: "Our medical standards are world class, but if we have to get more patients from the U.S. and other developed countries, we must match their hospital documentation standards for insurance companies to cover all the risks in the event of an adverse treatment outcome."

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