“It is the quality of our work which will please God and not the quantity.”

– Mahatma Gandhi.

The unquenched thirst for excellence has always been the most important guiding force for humanity. The desire to do a process or produce a thing which is better than the previous one has been the major motivation for mankind, since time immemorial. This has lead to redefining the word excellence so many times that now excellence is a milestone, waiting to be crossed. When there is a limitation of resources, economical or otherwise, the striving for excellence is compromised. When the resources are plentiful, the race towards perfection and excellence soars to newer unimaginable heights. This degree of ‘excellence’ which a thing possesses is defined as quality.

1.1 Resurgent India demands better quality of life

India is no more a country of lions and fakirs. India has emerged as one of the fastest growing major economy in the world as per the Central Statistics Organization (CSO) and International Monetary Fund (IMF). The per capita national income just after independence was Rs 274 in 1950. It increased slowly to Rs 6,270 in 1990. The Indian economy resurgence lead to the per capita national
income becoming Rs 58,534 in 2010 and Rs 88,533 in 2015 and it crossed 1 lakh mark to Rs. 1,03,219 in 2016-17 (Press Information Bureau GOI, 2017). The rapid economic growth of India has now ensured that the average household incomes will triple over the next decades and it will become the world’s 5th largest consumer economy by 2025, significantly ahead from the 12th position it occupies now (Ablett et al, 2013).

The Indian consumer’s paying capacity has significantly improved over the last few decades and so have their expectations for a better quality of life. The consumer now demands the best quality for everything in life and is even ready to pay a little more, if he is assured that the service or product meets a certain benchmark of excellence. ‘Quality of life’ is a recent concept and defining this term is difficult, as it is influenced by multidimensional factors that include everything from physical health, psychological state, level of independence, family, education, wealth, religious beliefs, a sense of optimism, local services and transport, employment, social relationships, housing and the environment. This term was originally used only by health care professionals, so it signifies the importance of ‘Health’ in Quality of life. The first principal, in the constitution of the World Health Organization (WHO), defines Health as ‘A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO, 1948).

These positive changes in the economy of India and the quest of better quality of life have impacted the spending pattern of the Indian citizens. An average Indian family used to spend 4% of his income on healthcare in 1995, and this share of average annual household consumption has risen to 9% in 2015 and is expected to be 13% in 2025 (Beinhocker et al., 2007). It is not that the disease burden has increased or the cost of healthcare risen steeply, it is the demand for better quality of life style and remaining disease free and healthy, that has lead to an increased demand for Quality Healthcare.
1.2 Global Focus on Quality Health Care

Over the years mankind has learnt many lessons through experiences and knowledge sharing. Yet the challenges faced by governments in both developed and developing countries is to decide which quality strategies would have the greatest impact on the outcomes delivered by their health systems. The strategies may be complemented by and integrated with existent strategic initiatives. The developed countries that already have well developed health care systems and adequate resources, still find themselves deficient on quality aspects, as the goals of outcomes are not successfully achieved and there are wide differences in the standards of healthcare. This is the reason why in the survey of Healthcare Access and Quality (HAQ) Index, developed and resourceful countries like the United Kingdom and United States of America are ranked behind, at 30th and 35th ranks. On the other hand, in developing countries, there is a need to optimize resource use and expand population coverage. The process of improvement needs to be based on sound local strategies for quality, so that the best possible results are achieved. India ranks at 154th position (Barber et al, 2015).

For much of mankind today, access to health care is severely limited and often financially out of reach. Governments have responded by formulating creative financing plans, human resource training, and implementing programs that increase a country's capacity to provide health care services while ensuring financial protection for its citizens. A puzzling issue confronting many governments is that even when formal public health care delivery systems are available and often provided free, patients pay out of pocket and get healthcare services from private providers (Berendes et al 2011). A quotation from the Institute of Medicine (USA) report, vividly summarizes the current state of affairs- “As medical science and technology has advanced at a rapid pace, the health care delivery system has floundered in its ability to provide consistently high quality care to all” (Danforth and Perrin, 2001).
1.3 The Health of Health Sector in India today

Healthcare has now become one of India’s largest sectors. Healthcare includes hospitals, biomedical equipment and devices industry, pharmaceutical industry, clinical trial industry, outsourced health services, telemedicine, medical tourism and health insurance. This sector is growing fast due to its increased coverage, variation in services and increasing expenditure by public as well private players.

The Indian healthcare sector is expected to register a Compound Annual Growth Rate (CAGR) of 22.9 per cent during 2015-20 to US$ 280 billion (Rs. 17, 94,300 Crores) (Frost and Sullivan, 2017). On a world stage, India has a competitive advantage because of its large pool of well-trained medical professionals. Medical treatment in India is also cost competitive compared to its peers in Asia and Western countries. The cost of surgery in India is about one-tenth of that in the US or Europe. Rising per capita income, increased health awareness, greater incidence of lifestyle diseases and improved access to health insurance would be the key contributors to growth of the Indian healthcare sector.

The private sector has become a vibrant force in India's healthcare industry, as it accounts for almost 74 per cent of the country’s total healthcare expenditure (Frost & Sullivan, 2017). Public-Private Partnerships (PPP) models are being encouraged. The Government of India is trying to develop the country as a global healthcare hub and is also providing policy support in the form of reduced excise and customs duty and exemption in service tax to support growth in healthcare. Investment in healthcare infrastructure is set to rise, benefiting both 'hard' (Hospitals) and 'soft' (Research & Development, Education) infrastructure. The telemedicine market in India is valued at US$ 7.5 million (Rs. 48 Crores) currently and is expected to grow at a CAGR of 20 per cent to reach US$ 18.7 million (Rs 119.8 Crores) by 2017 (Ministry of Health, GOI Report, 2017).
The Government of Gujarat has launched its new Health Policy-2016, with the objective to make available advanced healthcare services to those who are living in remote villages and do not have access to good quality of healthcare service. The state government is encouraging setting up of self-financed medical colleges in PPP model, with priority given to the remote districts of Tapi, Dahod, Panchmahal, Banaskantha, Bharuch and Amreli in first phase. In the last annual Vibrant Gujarat Summit 2017, the health department of Gujarat has showcased the state’s healthcare strategy to the international audience with the slogan ‘Accessible, Affordable and Quality Healthcare for All’.

On 1st February 2018, the Finance Minister of India, while presenting the ‘Union Budget: 2018-19’ announced a flagship ‘National Health Protection Scheme’ under which Rs 5 lakh cover will be provided per year to 10 Crore poor and vulnerable families in the country. This would be the world's largest government funded healthcare programme; and it would take healthcare protection to a new aspirational level. The government will also establish 1.5 lakh Health and Wellness Centres under the ‘Ayushman Bharat’ program and the next slogan after ‘Swachch Bharat’ is undoubtedly ‘Swastha Bharat’. In order to further enhance accessibility of quality medical education and health care, government will be setting up 24 new Government Medical Colleges and Hospitals by upgrading existing district hospitals in the country. This would ensure that there is at least 1 Medical College for every 3 Parliamentary Constituencies. The evident thrust towards ‘Healthcare’ by the government shows that there is a serious focus on quality in health care.

### 1.4 Dissimilarities in the India Growth Story

‘When any discussion on ‘Resurgent India’ and the increased demand for quality in healthcare takes place, a few dissimilarities in this growth story cannot be overlooked. The ‘Rich-Poor’, ‘Male-Female’ and the ‘Urban-Rural’ Divides are important issues.
India’s richest one per cent now hold a huge 58 per cent of the country’s total wealth. Just 57 billionaires in India now have same wealth ($216 billion) as that of the bottom 70 per cent population of the country. Women form 60 per cent of the lowest paid labour, but only 15 per cent of the highest wage-earners. It means that in India, women are certainly not among the top segment of wage earners but also experience wide gender pay gap at the bottom segment (PTI-TOI, 2017). The India Exclusion Report (2016) says that since 1990 growth was up to three times of the levels in the first four decades since Independence, but the rate of poverty reduction slowed down from 0.94% per annum during 1981-1990 to only 0.65% between 1990 and 2005. The headlines for this report in a leading newspaper read: ‘Rich-poor divide in India widening as economy grows!’ (Chauhan C, 2017)

“India lives in villages” said Mahatma Gandhi. Interestingly, even after almost 70 years of independence, though there has been substantial migration from rural to urban areas, still almost 68% of India continues to live in rural areas. Rural literacy rate is also much lower than the urban literacy rate and the urban female literacy rate is almost higher by 20% than the rural female (Mukunthan A, 2015).

With regards to healthcare, the disparities of Rich-Poor, Gender and Urban-Rural stand out as major challenges facing India today. The middle and upper classes, which generally live in the urban areas of India, have access to quality medical care in the corporate hospitals and private clinical establishments, but there is a premium cost associated. The well off urban Indian, who have health insurance or can afford this high cost, get this quality treatment, but a vast majority of urban dwellers have to depend on the government hospitals, urban health dispensaries, nursing homes and private clinics, which may be affordable but compromise on quality. There is a mushrooming of unqualified allopathic doctors, who practice as quacks in the sub urban regions and not only provide the worst quality of healthcare, but also subject the patients to health risks and commonly commit medical negligence in treatment. It is the poor people who live in rural areas, who
receive especially low-quality care. Despite significant increases in budgetary allocations through the National Rural Health Mission (NRHM) which was launched in 2005, the vast majority of rural households still rely on unqualified private sector providers for their primary health care need (Das and Mohpal, 2016).

The private sector plays a more dominant role in healthcare delivery in India. The public sector remains underfinanced and short staffed, even when majority of the rural and poor people have to depend on the government facilities and therefore their health needs are not met properly. The healthcare professionals tend to be concentrated around urban areas where people have more affordability, leaving rural areas under-served. The central and state governments do offer free treatment and essential drugs at government hospitals, but it is of no use in absence of doctors. On comparing ourselves with health care facilities in other parts of the globe, it is found that ‘Health Insurance’ is a major factor, because 76% of Indians do not have health insurance. India is short of nearly 500,000 doctors, with reference to the World Health Organization (WHO) norm of 1:1,000 populations. Though, as per the Indian Medical Register (IMR) the ratio of Doctor: Population is 1:1674, but because the IMR is not updated live, the estimated ratio is expected to be around 1:2000 only. The rural healthcare infrastructure is three-tiered and includes a sub-center, Primary Health Center (PHC) and Community Health Centre (CHC). Indian PHCs are short of more than 3,000 doctors, with the shortage up by 200% over the last 10 years. It is found that most rural households, therefore, prefer the private facilities as they are not satisfied (46.76%) with government doctors and secondly, 20.81% found public healthcare systems as relatively inaccessible. (Bhattacharjee and Mohan, 2017). India’s existing healthcare infrastructure in rural areas is just not enough to meet the needs of the population. Poverty is directly correlated with the lack of healthcare facilities. It is illustrated by the example of states with the highest proportion of undernourished children; Jharkhand and Chhattisgarh also have the worst infrastructure for institutional deliveries. India’s
healthcare spending is the lowest among BRICS (Brazil, Russia, India, China, and South Africa) nations, as are its health indicators.

1.5 Chapters Plan

This thesis is written in six chapters. After the first chapter of Introduction, second chapter is of the ‘Literature Review’. There is discussion in detail about the origin and development of concept of quality and health care service quality, with special emphasis on the Indian health care quality accreditation agency - National Accreditation Board for Hospitals (NABH) and quality healthcare in Medical College Hospitals. The third chapter discusses the research methodology in detail used in the present study, the definition of the problem, the aims, objectives, hypothesis, research tool and process of data collection. In the fourth chapter, the results and the analysis of the responses are presented as the primary data obtained through the administration of the questionnaire. The fifth chapter is dedicated to detailed analysis of this data obtained. Finally, chapter six presents the findings, conclusions and the recommendations. In this sixth chapter, suggestions for further study are also made. The Bibliography, Webliography and the Annexure are presented at the end of this thesis.