Chapter – 1

Introduction

The chapter includes overview of healthcare, Indian healthcare system and its working and developments. The chapter continues with basics of services and service quality, quality of Indian healthcare, need and scope of the study, objectives identified for conducting the study and significant contribution made by the study.

1.1 Introduction to HealthCare (HC)

Healthcare facilities include hospitals, primary healthcare centers, community healthcare centers, medical stores and diagnosis centers. One of the major objectives of any healthcare system in the world is to offer high quality healthcare services and respond to needs and expectations of users. Healthcare is a high involvement service concerned with health and well-being of a person. It is one of the fastest growing service sectors in not only developed but also developing countries (Dey et al., 2006). Indian healthcare service sector is expected to grow to USD 280 billion by 2020 (The Economic Times, dated 1st September, 2015; India Brand Equity Foundation, June, 2017). Healthcare needs to be sustainable as demands are increasing with limited resources (Faezipour and Ferreira, 2013). Factors such as rising income levels, ageing population, growing health awareness and changing attitude towards preventive healthcare are going to boost the demand of healthcare services in future. Today’s consumers are more aware and motivated to process the available information related to healthcare services. Patients are the key focus of any healthcare system. They are the customers of healthcare system with numerous expectations. Healthcare facilities are required to go beyond a medical view and should have holistic social approach. Just accurate diagnosis and treatment are not enough, patients need performance in each and every services they receive such as admission, discharge etc. (Angelopoulou et al., 1998). Good performance leads not only to returning of consumers to the same service provider but also to spreading of more favorable recommendations (Youssef, 1996). To determine whether the healthcare services are effective, one has to ensure that the patients are satisfied with the services provided. By improving effectiveness of healthcare services offered to patients, patients’
wellbeing would be improved and with improved wellbeing, patients are expected to become healthier and thus the number of patients reduces (Carlson and Gabriel, 2001).

Healthcare services are low in need recognition and search attributes as it is difficult for the customer/patient to evaluate the service before selecting the healthcare facility or experiencing service of a particular service provider. Individuals are not able to make choices about their treatments; they are being passive and leaving all decisions to the nurse or doctor (Gandjour, 2007; Shortell et al., 2007). Also, healthcare services are complex in experience attributes that means they can be evaluated only after experiencing a particular service but not before the service is provided (Hunter et al., 1982; Hunter and Schmidt, 1990; Budd and Raber, 1996; Lilford et al., 2007) and therefore patient satisfaction plays significant role.

1.1.1 Definition of Health

Health is a state of complete physical, mental and social well-being and not just the absence of disease or infirmity (World Health Organization, International Health Conference, 1946). Highest possible attainment of health, according to WHO, is a fundamental right of every human being without distinction of any kind. Health is a state of well-being, free of disease or infirmity, and a fundamental and universal human right (Saracchi, 1997). It is a dynamic state of well-being characterized by a physical and mental potential, which satisfies the demands of life commensurate with age, culture, and personal responsibility (Bircher, 2005). The role of government in ensuring that the healthcare delivery system of the country is performing well should be emphasized more importantly (The world health report, 2000).

1.1.2 Definition of HealthCare

Healthcare is the maintenance or improvement of health via the prevention, diagnosis, and treatment of disease, illness, injury, and other physical and mental deficiencies in human beings. It is delivered by health professionals/providers/practitioners. Dentistry, nursing, midwifery, medicine, pharmacy, psychology, physical therapy etc., are part of healthcare. It also includes work done in providing primary care, secondary care, and tertiary care, as well as in public health. Human resources, data system, financial systems and adequate infrastructure which include buildings, equipment, supplies etc. are the crucial elements of healthcare services (Kleczkowski et al, 1984).
Access to healthcare vary across countries, communities, and individuals, largely influenced by economic and social conditions as well as the health policies. Healthcare systems are establishments to meet the health needs of targeted populations. According to the World Health Organization (WHO), a well-functioning healthcare system requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; and well maintained health facilities and logistics to deliver quality medicines and technologies.

1.1.3 Public HealthCare

Public healthcare can be defined as a science dealing with the determinants of health at the population level (Winslow and Amory, 1920). It aims to understand influence of the social, cultural and economic determinants of healthcare and to make healthcare systems efficient channels for healthcare services delivery. It is a discipline which is built on the academic tradition of inquiry involving research, teaching and professional practice to prevent disease and promote health in populations (Winslow and Amory, 1920).

1.2 Indian HealthCare

“The importance of public healthcare in India’s development cannot be overemphasized. India is a demographically young country. The largest growing demographic segment in India over the next two decades would lie between 15-59 years. This provides a wide window of opportunity to enhance national growth provided one can productively deploy this large base of human resources.” - Dr. Manmohan Singh, Ex-Prime Minister of India at the launch of PHFI (Public Health Foundation of India, 2006).

International conference on primary healthcare, the Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public healthcare. India is a participant to the Alma Ata Declaration of 1978 and was dedicated to attainment of the goal of ‘Health for All by the Year 2000’ through provision of primary healthcare services across the country (Government of India, 1983; Chatterjee and Yilmaz, 1993). But India could not achieve reproductive health related goals (Srinivasan, 2000; Sood, 2000) and also could not develop a good quality healthcare infrastructure for rural people (Majumder, 1999).
A National Health Policy (NHP) was formulated in 1983. The policy could not achieve the expected outcomes in some areas. It was aimed at setting up a widely dispersed network of primary healthcare services through knowledgeable health volunteers. The National Health Policy (2002) states: “The existing public health infrastructure is not satisfactory. The medical facilities available are not sufficient. There are less number of personnel in the medical facility than that are prescribed in the norms, the public hospitals have obsolescent equipment and unusable buildings, required drugs are not available which leads to deterioration in the quality of services provided. In most urban areas, public health services are inadequate which is forcing people to avail private healthcare through out-of-pocket expenses”. Objective of NHP-2002 was to assess quality and efficiency of the existing public healthcare system. The major focus of the policy was to ensure equitable access to healthcare services for all citizens of the country. The policy summarized the need for improvement in the health status of the people. There is a need for enhanced funding and organizational restructuring of the public health initiatives at national level (National Health Policy, 2002). After thirteen years, NHP-2015 had been formulated and stated that there are high degree of urban-rural health inequities and problems related to access of healthcare services. The primary goal of the NHP-2015 is to strengthen the Indian healthcare system. It also included the investment in health, organization of healthcare services, easy access to technologies, developing human resources, prevention of diseases, promotion of good health etc. (National Health Policy, 2015). The NHP-2015 was based on the principles such as equity, universality, patient centeredness, providing good quality healthcare services, accountability, integrity, ethics, provision of affordable services (National Health Policy, 2015).

The National Health Mission (NHM) - 2006 included two sub-missions: National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). NHM was flexible and dynamic and it was intended to guide States in ensuring the achievement of universal access to healthcare by strengthening health systems and their capabilities. NHM aimed at providing universal, equitable, affordable access and quality healthcare services. It ensured that all public healthcare facilities or publicly financed private care facilities offer assured quality of healthcare services (NHM Framework for implementation, 2014). National Rural Health Mission (NHRM) was launched to address the health needs of states that had been identified as having weak public health indicators. National Urban Health Mission was launched on 20th
January 2014, to meet the healthcare needs of the urban population with the focus on urban poor and vulnerable sections.

The Ministry of Health and Family Welfare scrutinizes the workings of the Central Government and provides technical and administrative services. Since 1990, Indian Government has an active policy of building a positive economic climate for the Indian healthcare industry. The policy measures are lower direct taxes, income tax exemptions for five years for rural hospitals, custom duty exemptions for imported lifesaving equipment, income tax exemption for health insurance, subsidized allocation of land that has been acquired under the Public Acquisitions Act, 1894 and the provision for 100% FDI (National Health Policy, 2015).

The main intention of the National Health Policy, 2017, is to inform, clarify, strengthen and prioritize the role of the Government in shaping healthcare systems in the dimensions such as investments in healthcare, organization of healthcare services, prevention of diseases and promotion of good health through cross sectoral actions, developing human resources, access to technologies, encouraging medical diversity, building knowledge base, developing better financial protection strategies, strengthening regulation and health assurance (National Health Policy, 2017).

The healthcare sector in India is divided in public sector and private sector. The effectiveness of the healthcare system depends on the quality of services provided, the foremost reason for preferring public health services is its inexpensiveness and proximity. Public healthcare sector lags behind the private healthcare sector in terms of service quality, adequate staff, better technology, etc., (Chahal and Sharma, 2004). A large section of population is below poverty line and health and hygiene are not even up to the mark. Poor public health systems are the reasons for increased numbers of disadvantaged. Due to excessive charges, many of the people could not afford to have medical treatment from the private health organizations. There are so many healthcare organizations in the country but they are not providing quality services to their patients. Medical care has not become affordable, not only for the Indian population who live below poverty line, but also for the middle income group. Lack of equipment and diagnostic tools, lack of adequate and timely treatment to patients, non-availability of healthcare facility, inadequate number of doctors, nurses and employees etc. are the major
problems of Indian healthcare delivery system. Seventy percent of the population in India lives in the rural areas (India Brand Equity Foundation, January, 2017) and they are not even aware of the diseases caused by water, bad sanitation and food.

Healthcare has become one of India's largest sectors both in terms of revenue and employment. The industry is growing at a tremendous pace owing to its strengthening coverage, services and increasing expenditure by public as well private players. In 2015, Indian healthcare sector became the fifth largest employer, both in terms of direct as well as indirect employment, with total direct employment of 4,713,061 people (Frost and Sullivan, 2015). The market value of healthcare in the year 2015 was USD 100 billion followed by USD 110 billion in the year 2016 (India Brand Equity Foundation, June 2017). The total industry size is expected to touch USD 280 billion by 2020 (The Economic Times, dated 1st September, 2015; India Brand Equity Foundation, June, 2017). Government of India (GOI) has allocated Rs. 33,152 crore in FY 2015-16 for Ministry of Health and Family Welfare i.e. MoHFW (The Times of India, dated 28th February, 2015) and Rs. 48,853 crore in FY 2017-18 (Budget Briefs, 2017). Allocation of Rs. 19,120 crores has been made for NRHM in FY 2013-14 (National Rural Health Mission report, 2013-14) and Rs. 21,189 crores in FY 2017-18 (Budget Briefs, 2017). Under NUHM, a provision of Rs. 1,000 Crores has been made in 2013-14 (National Rural Health Mission report, 2013-14) and Rs.752 crore in FY 2017-18 (Budget Briefs, Vol.9, Issue 4). There is immense scope for enhancing healthcare services penetration in India, thus presenting ample opportunity for development of the healthcare industry (India Brand Equity Foundation, January, 2017).

Healthcare industry has started growing due to its strengthening coverage, services and increasing expenditure by public as well private players. Factors for growth in healthcare sector are increasing population, growing health awareness and preventive healthcare, hub for innovation and research and development due to relatively low cost clinical research, quality healthcare coupled with skilled medical professional, trust on medical tourism, improving health insurance penetration, conductive policies for encouraging Foreign Direct Investment (FDI) etc. (Frost and Sullivan, 2017).

The public healthcare system in India consists of state-owned healthcare facilities which are funded and controlled by the government of India. Some of these are controlled by agencies of
the central government and some are controlled by the governments of the states of India. The governmental ministry that controls the central government interests in these facilities is the Ministry of Health and Family Welfare. Most of the treatments in the healthcare facilities are either fully or partially subsidized as they are funded by government.

### 1.3 Services and Quality of Services

#### 1.3.1 Services

Services are economic activities offered by one party to another, in exchange of money, time and effort, often time-based, performances bring about desired results to recipients, objects, or other assets for which purchasers have responsibility (Edvardsson et al., 2005). Kotler et al. (2009) defined services as any act or performance one party can offer to another that is essentially intangible and does not result in the ownership of anything. The majority of services by nature have intangibility, heterogeneity and inseparability as their main characteristics (Regan, 1963; Rathmell, 1966; Shostack, 1977; Zeithaml et al., 1985). Unlike products, the production, distribution and consumption of services are simultaneous processes. Also, they are not storable like products. Services are the processes or activities created during buyer-seller interactions where customers participate in the production process (Lovelock 2004; Gronroos, 2007; Hoffman et al., 2011).

![Service and its components](Source: Payne B., 2018)
Characteristics of Services

Differences in the nature of services and products have been highlighted in the service literature, which are considered to create major challenges for the service marketers as well as consumers of the services. For the understanding of differences between products and services, authors have proposed a number of characteristics which describe unique nature of services. These are summarized as intangibility, inseparability, heterogeneity and perishability (Regan, 1963; Rathmell, 1966; Shostack, 1977; and Zeithaml et al., 1985). Following are the major four characteristics of services:

Intangibility

The idea of services was introduced by Regan (1963) being ‘activities, benefits or satisfactions that are offered for sale, or provided in connection with the sale of goods’. According to Levitt (1981), the degree of intangibility can be used as a means of distinguishing products and services. Other studies advocated that intangibility could not be used to distinguish clearly between all products and services. In the opinion of Bowen (1990) and Wyckham et al., (1975), concept of tangibility-intangibility is difficult for people to grasp. Bowen (1990) has provided empirical evidence to support this view. According to Onkvisit and Shaw (1991), importance of intangibility is over emphasized and they suggested that productive capacity depends on what a service provider offers and not on the intangible or tangible nature of the offer.

Figure 1.2: Characteristics of services
Inseparability


Heterogeneity

Due to heterogeneous nature, the services carry high potential for variability in delivery (Zeithaml et al., 1985) but this creates problem with labour requirements as it is delivered by different people and performance of people can vary from day to day (Rathmell, 1966; Carman and Langeard, 1980; Zeithaml, 1985; Onkvisit and Shaw, 1991). It is possible to have more flexibility and customization due to heterogeneity (Onkvisit and Shaw, 1991) and it can work as a point of differentiation (Wyckham et al., 1975).

Perishability

Services cannot be stored or carried forward to a future time period (Rathmell, 1966; Donnelly, 1976; Zeithaml et al., 1985). Time dependent and time important nature of services make them perishable (Onkvisit and Shaw, 1991). According to Hartman and Lindgren (1993), perishability is primary concern of the service producer as the consumer only becomes aware of the issue when there is insufficient supply and he/she has to wait for the service.

1.3.2 Quality

“Quality” word is originated from the Latin word “qualis”, which means ‘what kind of’ (Glare, 1983). Quality is defined as ‘The degree of excellence, superiority of kind, and a distinguishing attribute’ by the Merriam-Webster Dictionary (2010). It is difficult to define quality because of its subjective nature with intangible characteristics. It is an elusive and abstract concept, with many meanings and interpretations (Seawright and Young, 1996). Meaning of quality may be different for different people.
Therefore, definitions of quality vary depending upon whose perspective is taken and within which context it is being considered. It has been defined as ‘value’ (Feigenbaum, 1951), ‘excellence’ (Peters and Waterman, 1982), ‘conformance to specifications’ (Gilmore, 1974), ‘conformance to requirements’ (Crosby, 1979), ‘fitness for use’ (Juran, 1988), and ‘meeting and/or exceeding customers’ expectations’ (Parasuraman et al., 1985). Quality has come to be recognized as a strategic tool for attaining operational efficiency and improved business performance (Garvin, 1983; Anderson and Zeithaml, 1984; Boller and Babakus, 1992), for both the goods and services sectors. It is one of the most competitive priorities and a prerequisite for the management of any organization. Improvement in quality has become necessity in today’s competitive markets. Quality provides path for value creation for companies and customers. In global business environment, delivery of high quality service is the driving force for the success of service organization (Thompson et al., 1985). Quality improvements result in a sustainable competitive advantage (Sureshchandar et al., 2002a). Therefore, the measurement and management of quality has become a major issue for survival as well as growth of all service firms. Quality improvement is the major factor that affects customer satisfaction and increases purchase intention among consumers for both,
manufacturing sector and service sector (Oliver, 1980). Quality is the key determinant of consumer satisfaction (Omar and Schiffman, 1995, Radwin, 2000, Gremler et al., 2001).

### 1.3.3 Service Quality

Service quality has been defined as a global judgment or attitude, relating to the superiority of the service and it involves evaluations of the outcome - what customer actually receives from service and process of service act - the manner in which service has been provided (Parasuraman et al., 1985, 1988). It is a difference between consumer expectations (what they want) and their perceptions about the services (what they receive) (Parasuraman et al., 1985, 1988).

Service quality is an important element in services marketing. The service quality framework varies from service to service, as services are heterogeneous. The distinctive nature of services requires a distinctive approach in defining and measuring service quality. The service marketers consider various constructs like service quality, consumer satisfaction and behavioral intentions for development of the marketing strategies (Sohail, 2003; Shaikh et al., 2008; Padma et al., 2010; Mehra, 2011; Aliman and Mohamad, 2013; Chang et al., 2013). Knowledge concerning to customer perceptions about the quality of service provided helps a firm concentrate on the areas that directly influence their competitive advantage and not focusing on the ones which waste the resources. Thus, assessment of quality of services is much more complicated unlike products. Instead of being a function of statistical measure, service quality assessment is a function of customer perceptions about the services (Cunningham and Young, 2002).

Service industry is picking its pace in current situation. Rising income levels, ageing population, growing health awareness and changing attitude towards preventive healthcare is expected to boost demand of healthcare services in future.

### 1.4 Service Quality in HealthCare

Improvement of service quality and its measurement is one of the important issues for the healthcare sector in the current era, as the service sector is encountering stiff competition (Garvin, 1983, Anderson and Zeithaml 1984, Boller and Babakus, 1992). Due to high
involve
ment property of healthcare services, they have a distinct position among the other
services. Healthcare quality is the application of medical science and technology in a manner
that maximizes its benefit to health without correspondingly increasing the risk (Donabedian,
1980). Service quality has been considered as an important element while consumer is making
choice of a hospital (Lynch and Schuler, 1990). In healthcare, quality can be defined as the
totality of features and characteristics of product/service that depends on its ability to satisfy
stated and/or implied needs (Korwar, 1997). Effectiveness of the service provided can be
determined by whether the patient is satisfied or not (Dey et al., 2006). Quality of care can be
defined as ‘provision of care that exceeds patient expectations and achieves the highest
possible clinical outcomes with the resources available. Ovretveit (1992) suggested three
dimensions; professional quality, client quality and management quality to improve overall
healthcare quality. Professional quality refers to whether consumer needs have been met using
correct techniques and procedures. Client quality can be defined as whether direct
beneficiaries feel that they get what they want from the services. Management quality means
ensuring that services are delivered in a resource-efficient way. Good healthcare quality deals
with providing patients with appropriate services in a technically competent manner, with
good communication, shared decision making and cultural sensitivity (Schuster et al., 1998).
Healthcare service quality represents a multidimensional concept reflecting a judgment about
whether services performed for a patient were appropriate and whether they were delivered
with due attention to the doctor/patient relationship (Martinez, 1999).

Healthcare quality means doing the right things right with continuous improvements, attaining
the best possible clinical outcome, retaining talented staff and maintaining sound financial
performance, and satisfying all customers (Leebov et al., 2003). It is very difficult to
reproduce the same healthcare services as it varies for producers, customers, places and time.
The factors such as education/training, experience, individual abilities and personalities vary
across the patients and thus healthcare professionals provide services differently (Joss and
Kogan, 1995; Jun et al., 1998; McLaughlin and Kaluzny, 2006). In different countries and for
different types of healthcare services, satisfied patients are more likely to return to the same
provider and recommend them to their families and friends (Headley and Miller, 1993; Taylor
and Baker, 1994; Bendall-Lyon and Powers, 2004; Otani and Harris, 2004; Zineldin, 2006;
Choi et al., 2005; Shabbir et al., 2010; Sivakumar and Srinivasan, 2010). Because satisfaction
reflects positive judgments patients form about their healthcare service experiences, satisfied patients appear to have more trust in their providers, more confident about their dealings and more willing to recommend them to others.

1.5 Service Quality in Indian Healthcare – Urban and rural healthcare facilities

Efforts to improve the quality of healthcare services in low-resource settings, including India, have typically focused on structural constraints (Das and Hammer, 2014). Recent studies in low-income countries have documented low levels of provider knowledge, in both the public and the private sectors, and have found evidence of large gaps between providers’ knowledge and the care provided, sometimes called “know-do gaps.” (Das et al., 2015; Mohanan et al., 2015). In addition to providers’ lack of capacity or knowledge in healthcare settings, low quality of care could also be due to the lack of incentives in the health system or information problems in the healthcare market, combined with a lack of accountability among providers and poorly functioning governance systems in the health system.

The service quality of healthcare is miserable in India and health outcome is far from satisfactory (Bajpai and Goyel, 2004; Bhandari, 2006; Satpathy and Venkatesh, 2006) and poor accessibility, infrastructure (facilities and equipment), and personnel are some of the major factors for the deteriorating quality of healthcare facilities. According to Sahay (2008) hospitals in India provide high quality treatment but they are very poor in customer service. Therefore, it is necessary to identify where and how to improve functional aspects of the services provided. Government of India has adopted a policy of healthcare reform to achieve health securities for all and to provide quality healthcare facilities within every district (John, 2010). The healthcare in India is in a bad condition because of the factors such as, exponential increase of the population, high level of corruption in government and private healthcare systems and lack of awareness amongst people (Kavitha, 2012). The healthcare service quality in India is unsatisfactory due to lack of knowledge, costly modern medical substances and treatments (Pramanik, 2016).

A village or a town is considered as the basic area of habitation. Throughout the world, in all censuses, this dichotomy of rural and urban area is recognized, also the data are presented
separately for both areas. According to census of India (2011), constituents of urban area are statutory towns, census towns and outgrowths. Statutory towns are the places with municipality, corporation, and notified town area committee. A census town has to satisfy three conditions: a minimum population of 5000 people, at least 75 percentage of male main working population is engaged in non-agriculture pursuits, density of population is at least 400 per sq. km. Outgrowth can be a village or a part of village which has urban features in terms of infrastructure and amenities such as roads, electricity, taps, drainage systems, educational institutes, post office, banks, medical facilities etc. All area other than urban are considered as rural area i.e. village is considered as rural area (Census of India, 2011).

Healthcare System in India has focused on increasing coverage in the rural areas. There has been little or no development of organized healthcare services for the vast urban areas. Urban poor get adulterated food and drugs. A large proportion of population suffers from protein calorie malnutrition (Kavitha, 2012).

The problem of healthcare access arises not only in huge cities but in rapidly growing small urban areas (Sharma et al., 2016). There is often a lack of accountability and cooperation in healthcare departments in urban areas, but difficult to pinpoint an establishment responsible for providing urban health services. Furthermore, health inequalities arise in urban areas due to difficulties in residence, socioeconomic status, and discrimination against unlisted slums and because of these urban people use non-governmental, private services which are plentiful (Sharma et al., 2016). Studies show that in contrast to rural areas, qualified physicians as they tend to be specialized in a specific field, they reside in urban areas where there is a higher market and financial ability for those services (De Costa et al., 2009).

1.6 Patient Satisfaction and Behavioral Intention

Kotler (1991) defined customer satisfaction as the level of a person’s felt state resulting from comparing a product’s perceived performance or outcome in violation to his/her own expectations. Smith and Houston (1982) claimed that satisfaction with services is related to confirmation or disconfirmation of service expectations. According to Churchill and Surprenant (1982) customer satisfaction is a cognitive response results from the consumption experience, whereas Westbrook and Reilly (1983) explained that customer satisfaction is
comprised of cognitive and affective dimensions. It is an emotional response (Cadotte et al., 1987). According to the American Marketing Association (AMA), customer satisfaction is the degree to which a customer’s expectations are fulfilled by products/services. Customer satisfaction can be considered as a result of post-choice response (Westbrook and Oliver, 1991), as a result of post-purchase (Fornell, 1992), and as a result of post-consumption of product or service (Mano and Oliver, 1993), and customer satisfaction is achieved during consumption of the product or service (Halstead et al., 1994). Vavra (1997) stressed that customer satisfaction is the end state which results from the consumption experience.

According to Pascoe (1983), patient satisfaction is reaction of a healthcare recipient about the salient aspects of the context, processes and result of their service experience. It is an appraisal by a patient, about an extent to which the care provided has met his/her expectations and preferences (Brennan, 1995). Patient satisfaction plays an important role in measuring the quality of care and continuing their services (Grogan et al., 2000). Sitzia and Wood (1997) evaluated patient satisfaction by measurement of the degree to which patients believed that care possessed particular attributes and patients’ evaluation of these attributes. There are two states of satisfaction, stable and dynamic. Stable state is related to healthcare generally and dynamic state is related to specific healthcare interactions (Sitzia and Wood, 1997). Patient satisfaction is the judgment made by patients on their expectations for care services that have been met or not in respect of both technical and interpersonal care (Campbell et al., 2000).

Behavioral intention (BI) is defined as a person's perceived likelihood or "subjective probability that he or she will engage in a given behavior". It is behavior-specific and operationalized by direct questions such as "I intend to [behavior]," with Likert scale response choices to measure relative strength of intention (Armitage and Conner, 2001). It could be positive or negative and will decide whether the customer would continue taking services of a service provider (Zeithaml et al., 1996; Anthanassopoulos et al., 2001; Ladhari, 2009). Post purchase behavioral intentions include positive word of mouth (where customers recommend a product or service to other potential customers), willingness to spend more on the company’s offering, commitment, repeat purchase, etc. (Parasuraman et al., 2005; Shapor et al., 2011).

In the context of healthcare services, behavioral intention begins with the notion that patients continue dealing with the hospital, and send positive messages to others, when they are
satisfied with a hospital (Elleuch, 2011). It is the potential behavior of patients which may probably be occasioned by the quality of service received and satisfaction (Zeithaml et al., 1996, Aliman and Mohamad, 2013). If a patient is satisfied with a hospital, the paper work like admissions formalities, discharge documentations and other processes, S/he will return to and recommend the same hospital (Kessler and Mylod, 2011).

1.7 Need and Scope of the study

Service quality and customer satisfaction are most important goals in current organizations that leads to positive behavioral intention of the customers. Many organizations have now shifted the paradigm of service quality to customer’s perspective (Parasuraman et al., 1985). Relying on this paradigm; a customer will judge the quality of service if the service meets his/her expectations (Gronroos, 1984; Parasuraman et al., 1985, 1988). The value of products and services that customers evaluate depending on their experience and perception is called satisfaction (Liljinder and Strandvik, 1995). Service quality and customer satisfaction are inarguably the two core concepts that are at the crux of the marketing theory and practice (Spreng and Mackoy, 1996). It is required to have sustainability in healthcare services due to rising incomes, ageing of population and increasing awareness about health (Faezipour and Ferreira, 2013).

Patients are the end consumers of the healthcare services and their perception of the quality of service provided is the key factor in determining the use of services (Rao et al., 2006; Brahmbhatt et al., 2011). Healthcare service quality has the significant positive impact on patient satisfaction and behavioral intention (Naidu, 2009; Shabbir et al., 2010; Aliman and Mohamad, 2013; Amin and Zahora, 2013; Senic and Marinkovic, 2013; Panda and Das, 2014; Pentescu et al., 2014; Murti et al., 2013a; b; Naik and Byram, 2016). Public service organizations work on the socio-economic level and serve individuals and other organizations that need adequate, timely and effective responses (Vinagre and Neves, 2002). In public sector, quality measures function as a direct measure of accountability as well as providing information to hospital about the areas for improvement (Draper et al., 2001). Thus, a clear understanding of patients’ requirements and expectations is required (Walters, 2001; Baltussen et al., 2002; Sohail, 2003; Duggirala et al., 2008; Padma et al., 2010; Murti et al., 2013a; b).
By improving quality of services provided to patients, patient satisfaction can be improved and their behavioral intention can be influenced (Kim et al., 2008; Padma et al., 2010).

The healthcare services provided to people are free of charge and competition disappears from government institutions, which leads to lack of interest in identifying the views of patients about the healthcare service and indifference to their liking for these services. The present study tries to identify the factors that contribute to public healthcare service quality for urban and rural areas and also seeks to evaluate its effect on patient satisfaction and behavioral intention.

Healthcare service is considered to have high credence qualities as it is one of the people processing services involving high-contact encounters and the level of involvement by patients as well as doctors are high. The study makes an attempt to identify factors of service quality in public healthcare setting, including public hospitals, Primary healthcare centers and Community healthcare centers, for urban and rural areas of Surat district. The study considers inpatient department patients those who have stayed at least overnight in the healthcare facility. The study deals only with public health facilities and therefore private health facilities were excluded. Study does not consider the healthcare programs run by state or central government. It can suggest the areas that require attention by the service providers.

1.8 Objectives of the study

Following are the objectives of the present study:

- To study factors contributing to the healthcare service quality
  - a. To identify factors contributing to the healthcare service quality
  - b. To confirm factors contributing to the healthcare service quality
- To study the impact of service quality perceptions on patient satisfaction and behavioral intention
- To study significance of length of stay at healthcare facility on service quality gaps
- To identify and compare the service quality gap independently for urban and rural respondents
1.9 Significant contribution of the study

India is a country with population of 1.354 billion, 17.74 percentage of the population of the world, with around 22 percentage of the population, i.e. around 0.298 billion, live below poverty line. India has per capita expenditure of USD 68.6 billion (India Brand Equity Foundation, January, 2017).

The healthcare sector is one of the fastest growing sectors, with Compound Annual Growth Rate (CAGR) of 22.87 percentage, in India in terms of incremental growth by 2020 (India Brand Equity Foundation, January, 2017). By the end of 2015, India witnessed 1,56,926 Sub-centers, 1,96,312 hospitals and 3,601 Aayush Hospitals with 515 eye banks and 2,760 registered blood banks to support the hospital facilities. On an average, one hospital bed is available for 1,050 Indians (India Brand Equity Foundation, January, 2017). India has over one million doctors to serve 1.354 billion population, of these, only around 11 percentage are working with public healthcare center. (Refer figure 1.4). India is facilitated with one government doctor for every 10,189 Indian, one government hospital bed for every 2,046 Indian and one state-run hospital for every 90,343 Indians. India not only have lack of hospitals, doctors, nurses and health workers but also faces the issues related to disparities and inequalities in the quality of care and access to health services across states as well as between urban and rural areas.
For example, the state of Maharashtra has 1,53,513 registered doctors, the most in country compared to 792 registered with the state of Arunachal Pradesh, least in India. Also, only one out of five doctors in rural India are qualified to practice medicine (World Health Organization report, 2016). At India level, there are 80 doctors and 61 nurses for every one tenth of the million population against neighboring China with 148 doctors and 103 nurses for the same proportion of the population. Eliminating the unqualified doctors and nurses, the figure seems more scary with only 36 doctors and six nurses for every one tenth of the million population (The Hindustan Times, August, 2017).

Less than half of urban (42 percent) and rural (46 percent) of India opt for public healthcare services (The Wire, 2018). The leading reason for not using public healthcare is poor quality of care followed by non-availability of nearby facility, inconvenient timings, absence of health personnel and long waiting time. Rural areas in India have a shortage of medical professionals, 74 percent of doctors are in urban areas that serve the other 28 percent of the population which is a major issue for rural access to healthcare (Thayyil et al., 2013). The lack of human resources causes citizens to resort to fraudulent or ignorant providers. Doctors tend not to work in rural areas due to insufficient housing, healthcare, education for children,
drinking water, electricity, roads and transportation (De Costa et al., 2009). Additionally, there exists a shortage of infrastructure for health services in rural areas (Thayyil et al., 2013). In fact, urban public hospitals have twice as many beds as rural hospitals, which are lacking in supplies (Balarajan et al., 2011). Studies have indicated that the mortality risks before the age of five are greater for children living in certain rural areas compared to urban communities (Baru et al., 2010).

Users are becoming more involved in their own healthcare. Often the service providers misinterpret the quality of healthcare from patients’/consumers’ perspectives. Instead of asking care givers what patients are looking for, it is advisable to take patients’ viewpoint in judging quality of care provided. Patients’ quality judgments may provide real picture of the healthcare service quality. Existing literature made efforts to identify the service quality factors and its relationship with satisfaction and behavioral intentions. There is a need to study and understand sector specific and setting specific service quality factors, as it is not advisable to deal with all sectors and settings with single model.

Also, an individual is more or less likely to use health services based on demographics, position within the social structure, and beliefs of health services benefits (Andersen, 1968). According to Wolinsky, (1988), an individual would use a particular health service by the recommendation of resources found within households and the community. Household resources include economic status and the location of residence. Community resources contain access to healthcare facilities and the availability of medical personnel for assistance (Wolinsky, 1988).

According to Majumder and Upadhyay (2004), geographical factors, social structure, family characteristics, and quality of care are main determinants of the utilization of healthcare services. As education increases people are likely to avoid public health facilities, may be due to poor quality of services provided at the public health centers (Majumder and Upadhyay, 2004). Kamgnia et al. (2008), suggested that the satisfaction derived from the healthcare services is correlated with the type of service received and the area of residence. By measuring perceived quality of services from patients’ perspectives may help the management of public healthcare service providers to improve the service quality as required/needed by patients. Many researchers have studied service quality for healthcare sector and used popular models
of SERVQUAL and SERVPERF. But as suggested by references, the models are not completely applicable for various settings. The available model needs modification to be fit to measure the service quality with healthcare setup (Kettinger et al., 1995; Parasuraman et al., 1988; Sohail, 2003; Fowdar, 2005; Karatepe et al., 2005; Ladhari, 2008; Amin and Zahora, 2013). Also, People differ in their expectations and perceptions according to the demographics and geographical area.

By considering the above, it is essential to measure the service quality for second large populated country with lack of healthcare resources. The present study has not only constructed the 19-item Public HealthCare Service Quality (PubHCservQual) scale for measuring the perceived service quality gap for the public healthcare facilities but also validated the same. Also, it seeks to evaluate effect of the public healthcare service quality factors on patient satisfaction and behavioral intention. PubHCservQual helps the managers in situating service quality gaps for public healthcare facilities and provides the healthcare management insights on designing and implementing service quality improvement program.

1.10 Structure of the Thesis

The chapters of the thesis are settled as under:

Chapter 2: Review of Literature

The chapter begins with the concepts of service quality, service quality models, service quality in healthcare, patient satisfaction and behavioral intentions. Also, the literature on service quality effect on patient satisfaction and behavioral intentions has been presented for healthcare sector. The chapter identifies research gap for the study.

Chapter 3: Research Methodology

This chapter includes the research problem formulation and identification of research objectives. It describes suitable research design, sampling technique used. The structure, format and contents of the questionnaire have been discussed. Also, the procedures of the data collection and pilot study are covered in the chapter.
Chapter 4: Data Analysis

This chapter covers the detailed result of the analysis. Statistical Package for the Social Sciences (SPSS) version 21 and Analysis of a Moment Structures (AMOS) version 21 package are used for analyzing data.

Chapter 5: Findings and Conclusions

This chapter highlights major findings and conclusions of the study. It also discusses a theoretical and practical implication of the study. The chapter is not only limited to portray limitations of the study but extended to show path for future researchers to carry the study further.

Figure 1.5: Structure of Thesis