Full Length Research Article

HEALTHCARE SERVICES IN CORPORATE HOSPITALS – A SERVICE QUALITY PERSPECTIVE

*Dr. Sivakumar, M.

Department of Management Studies, Velammal College of Engineering and Technology,
Madurai – 625 009, Tamilnadu, India

ABSTRACT

The contribution of the services sector to the Indian GDP has increased from 43.7 per cent to 51.2 per cent between 1990-91 and 1998-99 (RBI annual report 1998-99). This growth of the service industry can be attributed to changing lifestyles, changing industrial economies and changing technology. And in spite of the pressure of political, legal, economic, social, technological and competitive forces on this sector, it has grown at an exponential rate. The service sector touches a wide gamut of activities, namely, health, education, welfare, communications, travel, banking, professional services, insurance, advertising, credit rating, information technology and so on. Business and employment opportunities promise to be in plenty in the private sector.

INTRODUCTION

Challenges for the Health Care Sector

The Indian health care sector with its highly fragmented hospital and health care systems, suffers from a skewed distribution of hospitals. In Maharashtra, there are 3115 hospitals; Kerala has 2040, whereas Himachal Pradesh has only 57 hospitals. This is primarily due to the difference in the extent of private sector participation in the health care sector. Ninety per cent hospitals are owned by private sectors in states like Andhra Pradesh, Maharashtra, Gujarat, Kerala and Tamil Nadu. The demand–supply gap for health care delivery is very large in India. In terms of number of hospital beds, India has less than one third of the WHO norm. According to the Mckinsey's Report of 2002, India has 1.5 beds per 1000 persons while China, Brazil and Thailand have an average of 4.3 beds for the same number of persons. The report of the World Health Organization (WHO) states that India needs to add 80,000 hospital beds each year to meet the demands of its population of which 40,000 beds must be added by the private sector.

Need for the Research

The consumers in health care industries are highly aware of the facilities at the various hospitals at the nearby cities. Their expectations are also growing at a faster rate. Due to globalization and liberalization, the competition in health care industry is also growing day by day. Hence, the health care management should analyze the needs of their customers consistently. They formulate the marketing strategies which are appropriate to their customer segment. They should enrich their marketing orientation in a continuous manner. The corporate hospitals are following these aspects very carefully and capture the market share also. The analysis on the marketing orientation and implementation of marketing strategies by corporate hospitals and their impact on the attitude of patients towards hospitals is the need of the era. Hence, the present study has made an attempt to analyze this aspect. Health care centres need to go beyond a medical view and embrace a holistic social approach to health care. Accurate diagnosis and treatment are no longer enough; patients need performance in all services they receive (Angelopoulou, *et al.*, 1998)[1]. Performance makes consumers return to same provider

Corresponding author: Dr. Sivakumar, M.
Department of Management Studies, Velammal College of
Engineering and Technology, Madurai – 625 009, Tamilnadu, India

1. Angelopoulou, A., Kangis, P. and Bakis, G., (1998), "Private and Public Medicine: A Comparison of Quality Perception", International Journal of Health Care Quality Assurance, 11(1), pp.14-21.

and spread more favourable word-of-mouth recommendations (Youseef, 1996)[2]. Consequently, in order to guide health care service providers towards better resource allocation while maximizing their profits, researchers are trying to identify priorities and preferences of patients among various health care quality attributes across different states, along different medical settings and for different type of consumers.

Statement of the Problem

Many writers (Barer, 1982[3], Feldman *et al.*, 1994[4] and Mosialos, 1991)[5] pointed out that it is difficult to measure the end-product of health care services. In most industries, customers can compare product performance and features, including price, with those of competing products / services. But patients do not have readily available measures to compare the quality of life that they have after treatment nor the relationship between price and quality for a given physician or course of treatment. Most health care organizations are multi-product or multi service, offering a range of services (Baron and Harris, 1995)[6]. According to Yucelt (1994)[7], the medical cost is often of secondary importance in life-threatening and urgent situations. However, Betta *et al.*, (1990)[8], reported that the consumerism has been slowly entering into the medical health service industry. Hence, the health care units are trying to provide maximum patients satisfaction. But the changes in patients' expectations are growing and changing due to the development in medical fields. The marketing strategies of the hospitals are playing an important role in this aspect. The success of the hospitals rests on not only better service quality but also on the appropriate marketing strategies (Yezdi and Shirley, 2002;[9] Godiwalla, 1983)[10]. Hence the important problems faced by the hospitals in the competitive world are at two dimensions namely patient satisfaction and the marketing strategies of the hospitals.

2. Youssef, F.N. (1996), "Health Care Quality in NHS Hospitals", International Journal of Health Care Quality Assurance, 17(1), pp.15-26.
3. Barer, M.C. (1982), "Case Mix Adjustment in Hospital Cost Analysis Information Theory Revisited," Journal of Health Economics, 1(1), pp.53-82.
4. Feldman, R., Hillson, S.D and Winger, T-D (1994), "Measuring the Dimensions of Physician Work," Medical Care, 32(9), pp.943-957.
5. Mosialos, H., (1991), "The Economic Behaviour of the Hospital," Iartrikovima, May, pp.63-70.
6. Baron, S and Harris, K., (1995), Services Marketing, Text and Cases, Macmillan Business, pp.116-121.
7. Yucelt, U (1994), "An Investigation of Causes of Patient Satisfaction / Dissatisfaction with Physician Services," Health Marketing Quarterly, 12(2), pp.11-28.
8. Betta, P.A., Hildman and Ferguson (1990), "Developing a Successful Ambulatory QA Program," Nursing Management, 23(4), pp.31-33.
9. Yezdi, H. Godiwalla and Shirley, Y.Godiwalla (2002), "Marketing issues for Hospital Industry," International Journal of Health Care Quality Assurance, 15(1), pp.25-28.
10. Godiwalla, Y., (1983), Strategic Management: Broadening Business Policy, Praeger Publishers, New York, NY.

Research Gap Analysis

Even though there are so many studies related to the service quality in health care units, the satisfaction of the patients in health care industries, comparative study on private and public hospitals, quality management in health care industry and marketing programmes in health care industry, there is only a few studies related to the linkage between the marketing aspect of hospital services and the satisfaction of their patients especially in the Indian health care industry. Hence the present study has made an attempt to fulfill the research gap.

In order to fulfill the research gap, the researcher has proposed a research model for the present study. It is given in Figure 1.1.
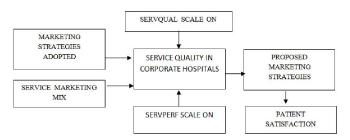

Figure 1.1. Proposed Research Model

On the basis of the proposed research model, the objectives of the study has been designed.

Objectives of the Study

The objectives of the present study are confined to

(i)   To reveal the profile of the patients in the hospitals;
(ii) To analyze their perception on service quality and services offered by the hospitals;
(iii) To analyze the marketing orientation of the hospitals;
(iv) To examine the impact of marketing orientation of the hospitals on the perception of the patients on the hospitals.
(v)   To evaluate the marketing strategies adopted by the hospitals;
(vi) To analyze the impact of marketing strategies on the overall attitude towards the hospitals; and
(vii) To identify the suitable suggestions to the hospital management.

Research Design

The research design details the procedures necessary for obtaining the information needed to structure or solve research problems (Thomas, 1996)[11]. The research design consists of the types of information needed, the form of research design, measurement and scaling procedures, construct development, data collection, sampling procedure and plan of data analysis (Kitaeff, 1994)[12]. The descriptive

11. Thomas, T. Semon (1996), "Marketing Research Needs Basic Research", Marketing News, 28(6), March, p.34
12. Kitaeff, R., (1994), Marketing Research Competencies, Marketing Research: A Magazine of Management and Applications, 6(3) Summer, pp.40-41.

research design has been followed in the present study since the study has its own predetermined objectives and methodology to be followed to fulfill the objectives. Apart from this, the present study explains the attitude of the patients towards the health care services and also the perception of the staff on the marketing orientation and the strategies adopted by the health care units.

Population of the Study

The number of polyclinics in Madurai is the population of the present study. The distribution of hospitals (polyclinics) in Madurai is presented in Table 1.1

Table 1.1. Number of Polyclinics in Madurai During 2008-09

Sl.No.	Nature of Ownership	Number of Hospitals	Percentage to the Total
1.	Trust	46	24.73
2.	Limited Company	50	26.88
3.	Partnership	42	22.58
4.	Proprietorship	48	25.81
	Total	186	100.00

Source: District Collectorate, Madurai, Tamilnadu.

In Madurai, there are 186 polyclinics. Out of the 186 poly clinics, 26.88 per cent of the polyclinics are run by limited companies. It is followed by proprietorship and trust which constitute 25.81 and 24.73 per cent to the total respectively. The remaining 22.58 per cent of the polyclinics are run by partnership concerns.

Sampling Procedure of the Study

The sampling procedure followed in the present study is multi-stage random sampling since the samples are selected at three different stages. At the initial stage, all the 186 hospitals have been included for the present study. Hence it is a census study. At the second stage, the patients are selected as the sample of the part of present study. In total, three patients are selected from each hospital purposively for the study. Hence it is the purposive sampling at this stage. The total sample size of patients came to 558. Since the response rate on the interview schedule is 55.37 per cent to the total of 558, the number of sampled patients came to 309. At the third stage, two doctors and two staff (nurses and administrative staff) have been taken as sample from each hospital. These doctors and staff are selected at random. The sampled doctors and staff are 744 (372+372). Since the response rate from the doctors and staff are 32.53 and 72.04 per cent to its respectively, the total sampled staff (doctors and staff) came to 389. At this stage, it is related to random sampling. Hence, the applied sampling procedure of the study is multi-stage sampling (Tripathi, 2005)[13].

Construct Development

Since the present study is completely based on primary data, the data have been collected through the structured and pre-structured interview schedule. There are two separate interview schedules have been prepared; one is for the patients and another is meant for doctors and staff. The schedule for patients consist of four important parts. The first

part covers the profile of the patients whereas the second part includes the perception of the patients on service quality of hospitals. The third part consists of the perception of the patients on important services in hospitals whereas the fourth part includes the patients overall attitude towards hospitals. The interview schedule for doctors and staff consists of three important parts. The first part explain the profile of the health care organization. The second part covers the staff view on the marketing orientation of the hospitals whereas the third part consists of the perception of the staff on the implementation of marketing strategies by the hospitals. A proper care was taken to include the variables related to service quality, services offered by hospitals, overall attitude towards hospitals, marketing orientation and market strategies. A pre test was conducted among 30 patients and 30 staff (including doctors and staff) in hospitals. Based on the result of pre-test, certain modifications, alterations and deletions have been carried out. The final draft of the interview schedule has been used for the data collection.

Collection of Data

The data from patients and staff have been collected with the help of two separate interview schedules. Out of 558 patients from the 186 hospitals, the responded patients are only 309 patients within a period of three months of time. At the same time, out of the 372 doctors and the 372 staff (nurses and administrative staff) in the 186 hospitals, the fully responded doctors and staff are 121 and 268 respectively. Hence, 309 patients and 389 staff have been included for the study.

Limitations of the Study

The present study is subjected with the following limitations.

1. The present study is confined to Madurai only. Hence the result of the study may not be generalized.
2. No scientific sampling procedure has been followed to select the samples especially the patients, doctors and staff in health care units since there is no proper details of population related to the above said three variables.
3. The mean score on the variables related to marketing orientation and implementation of marketing strategy in hospitals among the doctors and staff are treated as the marketing orientation and marketing strategies in hospitals.
4. Since the corporate hospitals in Madurai is very limited, the present study treats all the polyclinics in Madurai as the corporate hospitals.
5. On the basis of the number of beds in hospitals, the hospitals are classified into big and small hospitals.
6. All the descriptive variables related to service quality, services offered by hospitals, marketing orientation and marketing strategies are measured by Likert point scale.
7. The impact analysis is carried out on an assumption of linear relationship between dependent and independent variables and
8. The perception on service quality and overall attitude towards hospitals regarding particular hospital are computed by the mean score of the above said aspects among the number of patients in that hospital.

Summary of Findings

The important nativity among the patients is urban. The dominant age groups among the patients are 51 to 60 years and

---

13. Tripathi, P.C. (2005), A Text Book of Research Methodology in Social Sciences, Sultan Chand & Sons, New Delhi, pp.130-131.

above 60 years. The most important age group among the urban and the rural patients are 51 to 60 years. The important gender among the urban and rural patients is male. The important level of education among the patients is under graduation and school level. The most important levels of education among the urban and the rural patients are under graduation and school level respectively. The dominant occupations of the patients are private employment and business. The most important occupations among the urban and the rural patients are private employment and agriculture respectively. The dominant marital status among the urban and the rural patients are married. The important personal incomes per month among the patients are Rs.20,001 to 30,000 and Rs.10,000 to 20,000. The most important personal income among the urban and the rural patients is Rs.20,001 to 30,000. The important nature of family among the patients is nuclear family system. The dominant family sizes among the urban and the rural patients are 3 to 4 and 5 to 6 respectively. The important number of earning members per family among the respondents is one. The number of earning members per family is higher among the urban respondents than among the rural respondents.

The dominant family incomes per month among the patients are Rs.24,001 to 36,000 and Rs.36,001 to 48,000. The most important family income among the urban and the rural patients is Rs.24,001 to 36,000. The level of sociability among the urban patients has been identified as higher than that of the rural patients. The level of media exposure is found higher among the urban patients than among the rural patients. Regarding the innovativeness, the important level among the patients is moderate level. The level of innovativeness among the urban patients is found higher than among the rural patients. The personality trait score is higher among the urban patients than among the rural patients. The service quality of hospitals has been measured with the help of twenty five variables. The highly perceived service quality variables among the urban patients are all services under one roof, service to the expectations of patients and water and basic facilities. Among the rural patients, these are reliability of service, handling of queries and all services under one roof. Regarding the perception on service quality variables among the urban and the rural patients significant difference has been noticed in the perception on knowledgeable staff, well equipped operation theatre, handling of queries, cleanliness of the hospitals, reliability of service, service to the expectations of patients, neatly dressed staff, physician co-operation, prompt service and delivering service to the patients.

The important service quality factors identified by the factor analysis are empathy, responsiveness, reliability, assurance and tangibles. The highly perceived service quality factors among the urban patients are reliability and tangibles whereas among the rural patients, these are also reliability and tangibles. But the rate of perception on these service quality factors is identified as higher among the rural patients. Regarding the perception on service quality factors among the urban and the rural patients significant difference has been noticed in the case of responsiveness, reliability, assurance and tangibles. The significantly associating important profile variables with the perception on the service quality factors are age, personal income, family income and personality traits of the patients. The important discriminant service quality factors

among the urban and rural patients are reliability and responsiveness whereas these two are higher among the rural patients than the urban patients. The important scores on the overall perception on the service quality in hospitals among the patients are moderate and high. The most important level of overall perception on the service quality factors among the rural patients is lesser whereas among the urban patients, it is higher. The perception of the patients on the important aspects in hospitals has been examined with the help of their perception on physician behaviour, supporting staff behaviour and atmospherics. The highly perceived variables in physician behaviour among the urban patients are diagnostic way and professionalism whereas among the rural patients, these are understanding needs of the patients and personal care. Regarding the perception on variables in physician behaviour, the significant difference among the urban and the rural patients have been noticed in all the nine variables included for the analysis. The included nine variables in physician behaviour explain it to a reliable extent. The important summarized score on physician behaviour among the patients indicates only at lesser level. The most important level of perception on physician behaviour among the urban patients is poor whereas among the rural patients, it is higher.

The perception of the patients on the supporting staff behavior has been measured with the help of nine variables. The highly perceived variables among the urban patients are communication and regularity in attending the patients whereas among the rural patients, these are regularity in attending the patient and caring. Regarding the perception on the variables related to the supporting staff, the significant differences among the urban and the rural patients has been noticed in the case of caring, regularity in attending the patient, handling of queries and personal care. The included nine variables in supporting staff behaviour explain it to a reliable extent. The important level of perception on supporting staff behaviour among the patients is poor. The important level of perception among the urban patients is very poor whereas among the rural patients it is poor. The urban patients are rating the supporting staff behaviour poorly than the rural patients.

The perception of the patients on the atmospherics has been measured with the help of ten variables. The highly perceived variables among the urban patients are parking facility and canteen facility whereas among the rural patients, these are sanitary facility and parking facility. Regarding the perception on the variables among the urban and the rural patients' significant difference has been noticed in the case of all the ten variables. The ten variables related to atmospherics explain it to a reliable extent. The important level of overall perception on atmospherics among the patients is high. The most important level of overall perception on atmospherics among the urban patients is poor where as among the rural patients, it is high. The rural patients are rating the atmospherics highly than the urban patients. The significantly associating important profile variables with the perception on important aspects in hospitals are age, level of education, personal income, family income and personality trait score of the patients. The important discriminant aspects among the urban and the rural patients are perception on overall service quality and supporting staff whereas these are perceived highly among the rural patients.

The overall attitude towards hospitals among the patients has been measured with the help of nine variables. The highly perceived variables among the urban patients are service of experts, and diagnosis whereas among the rural patients, these are service of experts and in-patient service. Regarding the perception on the variables related to overall hospital service among the urban and the rural patients significant difference has been noticed in the case of out-patient care, in–patient care, reliability in service, response on the appeal of patients and follow-up actions. The included nine variables in the overall attitude towards hospital service explain it to a reliable extent. The level of overall attitude towards hospital service among the patients is high. The most important level of overall attitude among the urban patients is poor whereas among the rural patients, it is higher. The significantly and positively influencing perceptions on various aspects in hospitals on their overall attitude among the urban patients are overall service quality and physician behaviour. Among the rural patients, these variables are overall service quality, physician behaviour, supporting staff and atmospherics. The analysis of pooled data reveals that the significantly and positively influencing aspects in hospitals on the overall attitude towards hospitals among the patients are overall service quality, physician behaviour and supporting staff.

Maximum number of hospitals is having 60 and less than 60 beds and these are named as small hospitals. The hospitals which have beds above 60 are treated as big hospitals. The important ownerships in hospitals are limited company, proprietorship and trust. The most important nature of ownership in big hospital is trust whereas in small hospitals, it is proprietorship. The important numbers of departments in hospitals are 7 to 8 and 5 to 6. The most important number of departments in big hospitals is above 10 whereas among the small hospitals, it is 7 to 8. The number of departments in the big hospitals is higher than that of in the small hospitals. The important numbers of doctors per hospitals is 16 to 20 and 10 to 15 doctors which include the visiting and residential doctors. The most important number of doctors per big hospital is above 25 whereas in the small hospitals, it is 16 to 20 doctors. The number of doctors per hospital is found higher in the big hospitals than in the small hospitals.

The important numbers of nurses per hospital are less than 20 and 20 to 25. The most important number of nurses per big hospital is 35 to 40 whereas in the small hospital, it is less than 20 nurses. The number of nurses per hospital is identified as higher in the big hospitals than that of in the small hospitals. The important numbers of administrative staff per hospital are less than 10 and 16 to 20. The most important number of administrative staff per big hospital is above 25 whereas in the small hospital, it is less than 10. The number of administrative staff per hospital is found higher in the big hospitals than that of in the small hospitals. The important years of establishment among the hospitals are 11 to 15 years and 16 to 20 years. The most important years of establishment among the big hospitals are 11 to 15 years. Among the small hospitals, it is also 11 to 15 years. But, in total, the years of establishment of small hospitals are greater than the years of establishment of the big hospitals. The important numbers of patients attended per day per hospital in the present study are 151 to 200 and 100 to 150 patients. The most important number of patients attended per day in the big hospitals is above 250 whereas in the small

hospitals, it is 100 to 150 patients. The patients' turnover per day is higher in the big hospitals than that of in the small hospitals. The total number of administrative staff and doctors responded to the interview schedule are 268 and 121 respectively. At the same time, the total number of staff including administrative staff and doctors responded to the interview schedule in the big and the small hospitals are 113 and 276 respectively. The administrative staff includes the nurses and staff at the hospitals. The product mix orientation in hospitals has been measured with the help of eleven variables. The highly perceived variables among the doctors are check-up and treatment whereas among the staff, these two are delivery of service and service support. Regarding the perception on the variables related to the product mix orientation in hospitals, the significant differences among the doctors and staff have been noticed in the case of their views on service support, diagnosis, follow-up, check-up, communications, systems at the hospitals and good will.

The included eleven variables in Product Mix Orientation (PMO) explain it to a reliable extent. The important levels of product mix orientation in the hospitals are high and poor. The most important level of the PMO in the big hospitals is very high whereas in the small hospitals, it is high. The price mix orientation in hospitals has been measured with the help of seven variables. The highly viewed variables among the doctors are segmentation pricing and discriminatory pricing whereas among the staff, these are listed pricing and competitive pricing. Regarding the view on the implementation of price mix variables, the significant differences, among the doctors and staff have been noticed in the case of listed pricing, discriminatory pricing, cost plus pricing, segmentation pricing and competitive pricing. The included seven variables in price mix orientation explain it to a reliable extent. The level of price orientation is identified as higher in the big hospitals than in the small hospitals. The important levels of price mix orientation in hospitals are high and poor. The most important level of price mix orientation in the big hospitals is high whereas in the small hospitals, it is poor.

The place mix orientation in hospitals has been measured with the help of seven variables. The highly viewed variables among the doctors are various branches and market coverage whereas among the staff, these two are market coverage and logistics. Regarding the views on the variables related to place mix orientation in hospitals, the significant differences among the doctors and staff have been noticed in the case of market coverage, logistics, channel motivation, channel members, location of the hospital and focus on various market segmentation. The included seven variables in place mix orientation in hospitals explain it to a reliable extent. The important levels of place mix orientation in hospitals are high and low. The most important level of place mix orientation in the big hospitals is high. It is also high in the small hospitals, it is also high. But the place mix orientation in the big hospitals is higher than that of in the small hospitals. The promotion mix orientation in hospitals has been measured with the help of seven variables. The highly perceived variables among the doctors are media and current patients whereas among the staff, these are current patients and promotional budget. Regarding the view on the variables related to promotional mix orientation, the significant differences among the doctors

and staff have been noticed in the case of advertising, personal selling, promotional budget and current patients. The included seven variables in promotion mix orientation in the hospitals explain it to a reliable extent. The important levels of promotional mix orientation in hospitals are high and very high. The most important level in the big and the small hospitals is high. But the level of promotion mix orientation in the big hospitals is higher than that of in the small hospitals. The people mix orientation in hospitals has been measured with the help of six variables. The highly viewed variables among the doctors are customers and opinion leaders whereas among the staff, these are insurance companies and customers. Regarding the view on the implementation of people mix orientation, the significant differences among the doctors and staff have been identified in the case of customers, employees, celebrities, opinion leader and insurance companies.

The included six variables in the people mix orientation explain it to a reliable extent. The important levels of implementation of people mix orientation in the hospitals are poor and moderate. The most important level in the big and the small hospitals are high and poor respectively. The process mix orientation in hospitals has been measured with the help of nine variables. The highly viewed variables among the doctors are mechanism and technology whereas among the staff, these are technology and mechanism. Regarding the view on implementation of process mix orientation, the significant differences among the two groups of respondents have been identified in the cases of transparency, procedures, consistency, accuracy, speedy and systematic. The variables included in process mix orientation explain it to a reliable extent. The important levels of process mix orientation in the hospitals are poor and high. The most important level in the big hospitals is high whereas in the small hospitals, it is poor. The rate of implementation of process mix orientation in the big hospitals is higher than that of in the small hospitals. The physical evidence mix orientation on hospitals has been measured with the help of five variables. The highly viewed variables among the doctors are medical equipments and infrastructure whereas among the staff, these are infrastructure and tangible objects. Regarding the view on the implementation of physical evidence mix, the significant differences among the doctors and staff has been noticed in the cases of tangible objects, buildings, and furniture.

The included five variables in physical evidence explain the physical evidence mix orientation in hospitals to a reliable extent. The important level of physical evidence mix orientation in the big and the small hospitals is high. But the rate of implementation of physical evidence mix variables is higher in the big hospitals than that of in the small hospitals. The level of marketing orientation in hospitals has been computed by the weighted average score of each mix orientation in hospitals. The important levels of marketing mix orientation in hospitals are poor and high. The most important level in the big hospitals is high whereas in the small hospitals, it is poor. The rate of implementation of marketing mix orientation in the big hospitals is higher than that of in the small hospitals. Significant differences among the big and the small hospitals have been identified in the implementation of product, price, place, promotion, people and process mix. The higher discriminant power is seen in the case of product mix and promotion mix orientation. The important discriminant

marketing mix orientations among the two groups of hospitals are promotion and process mix orientation which are higher in the big hospitals compared to the small hospitals. The highly viewed service quality factors in the big hospitals are tangibility and reliability whereas in the small hospitals, these are reliability and assurance. Regarding the service quality factors, significant differences between the big and the small hospitals has been noticed in empathy, responsiveness, reliability, assurance and tangibility. The highly viewed aspects in big hospitals are the attitude towards physician behaviour and the overall attitude whereas in the small hospitals, these are attitude towards physician behaviour and atmospherics. Regarding the various aspects in hospitals, significant differences between the two groups of hospitals has been identified in the cases of physician behaviour, supportive staff behavior, atmospherics and overall attitude. The significantly associating important profile variables with the perception on various marketing mix orientation are number of patients attended per day, nature of ownership, number of administrative staff in hospitals and the number of departments in the hospitals. The discriminant validity is seen among the perception on the implementation of various marketing mixes in the hospitals.

The significantly and positively influencing marketing mix orientation on the perceptions on the overall service quality in the big hospitals are product, promotion and people mix orientation. In the case of the small hospitals, these are product, price, people, process and physical evidence mix orientation. The analysis of pooled data reveals that significantly and positively influencing marketing mix orientation on the perceptions on the overall service quality in the hospitals are product, price, people and physical evidence. The significantly and positively influencing marketing mix orientation on the overall perceptions on the hospitals is its product, promotion, people and process mix orientation. In the case of the big hospitals, these variables are product, place, promotion, people and process whereas in the case of the small hospitals, these are product, price, promotion, people, and physical evidence.

The marketing strategies adopted by the hospitals have been analyzed with the help six important measures namely medical specialization, financial accommodation, health packages, customer analysis, competitor analysis and promotional measures. The highly viewed variables in medical specialization among the doctors are the existence of departments of cardiology and urology whereas among the staff these, are the existence of the departments of neurology and nephrology. Regarding the view on the implementation of medical specialization, significant differences among the doctors and staff have been noticed in the cases of the existence of surgery, gynaecology, neurology, nephrology, urology, and cardiology. The included eleven variables in medical specialization explain it to a reliable extent. The important rates of implementation of medical specialization among the hospitals are poor and high. The most important level of implementation in the big hospitals is high whereas in the small hospitals, it is poor. The rate of implementation of market specialization in the big hospitals is higher than that of in the small hospitals. The rate of implementation of financial accommodation is examined with the help of eight variables. The highly viewed variables in it among the doctors are

insurance schemes and concession for regular customers whereas among the staff, these are company tie-up and group insurance schemes. Regarding the view on implementation of financial accommodation, significant differences among the doctors and the staff have been identified in the case of credit card acceptance, yearly medical schemes, group insurance schemes, company tie-up, discriminatory billing and segmentation treatment. The included eight variables in the implementation of financial accommodation explain it to a reliable extent. The important levels of implementation of financial accommodation in hospitals are high and poor. The most important level in the big and the small hospitals is high. The rate of implementation of financial accommodation in the big hospitals is higher than that of in the small hospitals. The implementation of health packages in hospitals have been measured with the help of seven variables. The highly viewed variables among the doctors are the implementation of executive health check-up and comprehensive health check-up. Among the staff, these two are implementation of group health package and pregnancy health package. Regarding the view on the implementation of variables in health packages, significant differences among the doctors and the staff have been noticed in the case of implementation of comprehensive and executive health check up, group health package and family health package.

The seven variables included in health packages explain it to a reliable extent. The important levels of implementation of health packages in hospitals are high and very high. The most important level of implementation of health packages in the big and the small hospitals is high. In total, the rate of implementation of health packages in the big hospitals is higher than that of in the small hospitals. The rate of implementation of customer analysis in hospitals has been examined with the help of eight variables. The highly viewed variables by the doctors are maintaining customers' data and periodical estimation of number of customers per month. Among the staff, these two variables are also the same. Regarding the view on the implementation of variables in customer analysis, significant differences among the doctors and staff have been identified in the case of periodical analysis on customers satisfaction, research and development cell for customer analysis, analysis on service utilization, occupancy rate in hospitals beds, estimate the customers needs and market segmentation analysis.

The included eight variables in customer analysis explain the implementation of customer analysis in hospitals to a reliable extent. The important levels of implementation of customer analysis in hospitals are high and very high. The most important levels in the big and the small hospitals are very high and high respectively. The rate of implementation of competitor analysis has been measured with the help of nine variables. The highly viewed variables among the doctors are estimation of threats given by competitors and market coverage analysis whereas among the staff, these are market coverage analysis and market share analysis. Regarding the implementation of variables related to competitor analysis, significant differences among the doctors and staff have been noticed in the case of estimation of strengths and weaknesses of competitors, estimation of threats given by competitors and market share analysis. The included nine variables in competitor analysis have explained it to a reliable extent. The

important levels of competitor analysis in hospitals are poor and very poor. The most important level in the big and the small hospitals is poor. But the rate of implementation of competitor analysis is somewhat higher in the big hospitals than that of in the small hospitals. The rates of implementation of promotional measures have been examined with the help of seven variables. The highly viewed promotional measures by the doctors are quality consciousness and positive words-of-mouth whereas by the staff, these two are special teams at hospitals and health camps at various places. Regarding the view on the implementation of promotional measures, significant differences among the doctors and the staff have been noticed in the case of positive words-of-mouth, advertisement, opinion leaders, company tie-ups, health camps at various places and quality consciousness. The included seven variables in promotional measures explain it to a reliable extent. The important levels of implementation of promotional measures in hospitals are high and very high. The important level of implementation at the big and the small hospitals are very high and high respectively. The rate of implementation of promotional measures in the big hospitals is higher than that of in the small hospitals.

Significant differences among the big and the small hospitals have been noticed in the case of implementation of medical specialization, financial accommodation, health packages, customer analysis and promotional measures. Higher discriminant powers are seen in the case of customer analysis and medical specialization. The important discriminant marketing strategies among the two groups of hospitals are medical specialization and customer analysis which are higher in the big hospitals than those of in the small hospitals. The significantly associating profile variables with the view on the implementation of marketing strategies in hospitals are number of administrative staff, number of nurses and number of departments in hospitals. The inter correlation between various marketing strategy variables indicates its discriminant validity.

The significantly and positively influencing variables in marketing strategies, on the overall service quality at the big hospitals are medical specialization, financial accommodation, customer analysis and promotional measures. In the small hospitals, these variables are financial accommodation, customer analysis and promotional measures. The analysis of pooled data also reveals the same result. The significantly and positively influencing variables in marketing strategy on the overall attitude towards hospitals are medical specialization, financial accommodation, customer analysis, competitor analysis, and promotional measures. In the case of the big hospitals, these variables are medical specialization, financial accommodation, customer analysis, competitor analysis and promotional measures whereas in the case of small hospitals, these variables are financial accommodation, health packages, customer analysis and promotional measures.

Concluding Remarks

The present study concludes that the perception on the service quality of hospitals is higher among the rural patients than among the urban patients. The perception on the physician behaviour, supporting staff and atmospherics in hospitals are also seen as higher among the rural patients than among the urban patients. It might be due to the expectation of the rural

patients which may be lesser than the expectation of the urban patients. The significantly influencing aspects in hospitals on the overall attitude towards the hospitals are the attitude of the patients on the overall service quality, physician behaviour and supporting staff behaviour.

The marketing orientation in the big hospitals is identified as higher than that of in the small hospitals. The significantly influencing marketing mix orientation of the hospitals on the overall perception on service quality of hospitals is their product, price, people and physical evidence orientation. The important discriminant marketing orientation among the big and the small hospitals are promotion and process mix. The implementations of marketing strategies to attract more patients are higher in the big hospitals than those of in the small hospitals. The important discriminant marketing strategies among the big and the small hospitals are medical specialization and customer analysis which are higher in the big hospitals than those of in the small hospitals. The significantly influencing marketing strategies on the overall attitude towards the hospitals among the patients are their medical specialization, financial accommodation, customer analysis, competitors' analysis and promotional measures. The study finally concludes that the health care services are different on the basis of their sizes. The hospitals which understand the needs of the customers from different segments very well are performing in a better manner. Hence, the hospitals are advised to do customers and competitors analysis initially and then formulate appropriate marketing strategies to succeed in the market.

Suggestions of the Study

Based on the findings of the study, the following suggestions are given. The survey on patients' satisfaction is highly needed to measure both the patients' expectations and perceptions on service and service quality. There should be a system at the hospitals which would collect the relevant data and analyze the data for appropriate policy implications in future. It should not be a time-bound process; it should be a continuous one. For that purpose, the hospital should establish data bank. The hospital managements are advised to deliver their services at par with the international standard. For that purpose, they have to implement the Total Quality Management Programmes at their hospitals. The TQM should include the responsibility management, service management, policy and strategy, operating instructions, personnel training, risk management, measurement and audit and tender evaluation.

Doctors on their part need to realize that quality in health care delivery should have measurable goals such as, the shortest possible waiting time for services, use of only the best quality drugs, 100 per cent sterilization of equipments, sanitary and secured hospital environment that aids healing, educating patients about their ailments and prompt referrals of cases to more capable specialists instead of keeping patients for ego purpose or pecuniary benefits. Doctors in private practice should embrace group practices, which will utilize resources better than sole proprietorships. Regular meeting of employees of private clinics for participative decision–making would boost staff motivation, and elicit quality service from every employee. The association of hospitals should expedite actions on proposed continuous medical training for private practitioners. Such programme should include management courses that go beyond book-keeping, to management philosophies like Total Quality Management (TQM) and Management By Objective (MBO) that focus on excellence in work performance. The hospitals are recommended ISO 9001:2000 certification in area of customer focus. Experiences of organizations holding the ISO 9001:2000 certificate, proved that implementation of quality improvement model will lead to a continuous improvement, reduction in expense, and proper allocation of resources. Furthermore, utilization of the model will prevent repeated activities and take into account the enhancement of customer satisfaction. Since the perception on service quality and services offered by the hospitals among the urban and rural patients are different, the hospital authorities should concentrate on this matter. They should design the services mixes according to the needs of the patients from the rural and the urban areas since their level of expectations are different. The rural patients may be related to the economy segment, whereas the urban patients may be related to the quality-seeking segment. So that, the appropriate marketing strategies should be designed by the hospital authority to satisfy the two groups of segments.

An analysis of the findings clearly shows that empathy, reliability and responsiveness are the critical dimensions in the service quality of hospitals. The resource allocation decisions should be re-evaluated in the light of expectations of the patients. The improving service quality requires planning and co-ordination. Most of all, it requires the total commitment of managers, doctors and staff. The 5 Ds of outcome measures should be properly analyzed by the hospital management which are the critical factors for the success of any health care organization. These are: (i) Death: Physician-specific monitoring of mortality rates (ii) Disease: Control of chronic illness (iii) Disability: Patient's ability to function and contribute to society (functional status) (iv) Discomfort: Control of pain, which interferes with health status and (v) Dissatisfaction: Consumer's evaluation of the process of health care delivery. The small hospitals are not performing up to the level of the big hospitals because of the nature of ownership and lack of resources that lead so the physicians and nurses are not able to provide more efficient services. They might be very productive but less efficient. Low level of efficiency has a positive correlation with the low quality of services on the treatment. The low professional income of the staff, the lack of management skills and the heavy work load, lead to insufficient professional control over the health care staff and processes. Hence, the small hospital management should think about their enlargement. If not possible by their own capital, they may go for some mergers and amalgamations of hospitals to perform well.

The health care organizations can use Malcolm Baldrige National Quality Award Criteria (MBNQA) as self-assessment tool to evaluate and to improve the quality of the hospitals. The MBNQA as self-assessment tool help the hospitals to lay the road map for world-class performance. The management and staff support is essential for the successful implementation of the MBNQA criteria in the hospitals. The social responsibilities of the hospitals are addressed through free medical camps, diseases eradication programmes, and treatment at concession rates. The hospitals should run on the basis of "highly reasonable ethical practice". If there is high cost of medical care with advanced technology and medicines,

the hospitals are advised to initiate the programmes like medical insurance to safeguard their governance and social responsibility. Health care process management has to be implemented in all hospitals in order to improve their quality of service. It includes the establishment of standard operating procedures for emergency, laboratory, routine admissions, and registrations. Feed back to improve health care processes is an important feature. Patient feedback should be obtained on services offered, technology / equipment used and treatment aspects of care. Doctors' inputs, latest information from medical journals and management inputs should be used for improving care processes. Support processes like pharmacy, central sterilization, diet and nutrition, and the like should be very well streamlined with other processes. Safety and security processes should be standardized.

Human resource development is to be effectively established in hospitals with the help of training, continuous learning and professional development activities. Work systems and procedures for recruitment (both internal and external sources) and career progression should be done in better spirit. Customers, co-workers and senior colleagues' feedback constitute an important component of performance appraisal, which has to be done once in every six months. The staff orientation, training-general skills and special skills, continuous medical education and continuous professional development programmes are the major efforts in training and skill development. Staff counseling and support programmes are a part of staff development in addition to training and career growth in order to establish better internal service quality in hospitals. The hospitals should establish the Hospital Information System (HIS) in order to provide sufficient data to evaluate the performance of the hospitals. Measurement analysis and knowledge management of medical care procedures and outcomes should be given primary importance. Mortality and morbidity data analysis along with medical records, department records and summary of results should be maintained.

Scope for Future Study

The present study is a base for future research. The future possible researches are given below. The service quality in private and public hospitals may be compared in future. The expectation and perception of the patients on particular group of hospitals may be focused in future. The perception of the patients on primary health centres may be analyzed separately. The attitude of the patients towards physician behaviour or supportive staff behaviour or the atmospherics may be examined separately at different hospitals. The marketing strategies of the hospitals and their performance may be discussed by the future studies. The rate of implementation of various quality programmes and its consequences in the hospitals may be studied in near future. The impact of advertisement in the health care industry may be discussed in future. A study on the organizational climate and the service quality of hospitals may be focused by future studies.

REFERENCES

Abramowitz, S., 1987. "Analyzing Patient Satisfaction: A Multi-Analytic Approach", Quality Review Bulletin, Vol.13, pp.122-130.

Abu Naser Ahmed Ishtiaque: Md. Shahriar Akter and Suntu Kumar Ghosh 2006. "Customer Expectations and Perceptions towards Health Services through SERVQUAL model-An Evaluation of Medical diagnosis services in Bangladesh", Prestige Journal of Management and Research, 10 (1&2), April-October, pp. 58-72.

Allen, E. Smith, Kerry, D. Swinehart 2001. "Integrated Systems Design for Customer Focused Healthcare Performance Measurement: A Strategic Service Unit Approach", International Journal of Health Care Quality Assurance, Vol.14, No.1, pp.21-28.

Angelopoulou, A., Kangis, P. and Babis, G, 1998. "Private and Public Medicine: A Comparison of Quality Perception", International Journal of Health Care Quality Assurance, 11(1), pp.14-21.

Arnold, P.J., and Reeves, T.C., 2006. "International Trade and Health Policy: Implications of the GATS for US Health Care Reforms", Journal of Business Ethics, Vol.63, No.4, pp.313-332.

Atun, R.A., 2003. "Doctors and Managers Need to Speak a Common Language", British Medical Journal, Vol.326, March, p.655.

Babakus, E. and Glynn, M.W., 1992. "Adapting the SERVQUAL Scale to Hospital Services: An Empirical Investigation", Health Services Research, 26 (6), pp.767-786.

Barer, M.C. 1982. "Case Mix Adjustment in Hospital Cost Analysis Information Theory Revisited," Journal of Health Economics, 1(1), pp.53-82.

Barry, Davies, Steve Baron, Tony Gear and Martin Read 1999. "Measuring and Managing Service Quality", Intelligence & Planning, 17(1), pp.33-40.

Betta, P.A. 1990. "Developing a Successful Ambulatory QA Program," Nursing Management, 23(4), pp.31-33.

Bopp, K.D., 1990. "How Patients Evaluate the Quality of Ambulatory Medical Encounters: A Marketing Perspective, "Journal of Health Care Marketing 10, No.1 pp. 6-15.

Borden, N.H. 1964. "The Concept of the Marketing Mix", Journal of Advertising Research, June, Vol.4, pp.2-7.

Boscarino, J.A., 1992. "The Public's Perception of Quality Hospitals II: Implications for Patients Surveys", Hospital and Health Care Services Administration, 37 (1), Spring, pp.13-35.

Bowers, M.R., Swan, J.E., Koehler, and William, F., 1994. "What Attributes Determine Quality and Satisfaction with Health Care Services?", Health Care Management Review, 19 (4), pp.49.

Boyt, W., and Schi Browskey, A., 2000, "Obstetrical Care and Patient Loyalty", Marketing of Health Services, 19 (Spring), pp. 13-19.

Brady, Michael, K. and Cronin Joseph 2001. "Some New Thoughts on Conceptualizing Perceived Service Quality: A Hierarchical Approach", Journal of Marketing, 65 (3), pp.34-49.

Brown, S.W. and Bond, E.U III 1995. "The Internal / External framework and Service Quality: Toward theory in Services Marketing", Journal of Marketing Management, February, pp.25-39.

Brown, Tom, J., Gilbert, A. Churchill and J. Paul Peter 1993. "Research Note: Improving the Measurement of Service Quality", Journal of Retailing, 69(1). Spring, pp.31-46.

Brysland, A. and Curry, A. 2001. "Service Improvement in Public Services Using SERVQUAL", Management Service Quality, Vol.11, No.6, pp.389-401.

Bulcke, D., Den, V., Zhang, H. and Li, X., 2000. "Interaction Between Business Environment and the Corporate Strategic Positioning of Firms in the Pharmaceutical Industry", Management International Review, Fourth Quarter, pp.253-577.

Buttle, F. 1996. "SERVQUAL: Review, Critique and Research Agenda", European Journal of Marketing, Vol.30, No.1, pp.8-32.

Carman, J.M., 1990. "Consumer Perceptions of Service Quality: An Assessment of the SERVQUAL Dimensions", Journal of Retailing, 66, Spring, pp.33-55.

Chahal, Hardeep 2003. "Strategies of Enhancing Consumer Satisfaction Rural Health Services in J & K", Indian Journal of Marketing, 33 (9), pp.13-17.

Chahal, Hardeep and Sharma. R.D., 2004. "Managing Health Care Service Quality in a Primary Health Care Centre", Metamorphosis – Journal of Markting Research, Vol.13, No.2, pp.112-131.

Choi, K.S., Lee, H. Kin, C., and Lee, S., 2005. "The Service Quality Dimensions and Patient Satisfaction Relationships in South Korea Comparison Across Gender, Age and Types of Service", The Journal of Service Marketing, 19(3), pp.140-149.

Clara Martinez Fuentes 1999. "Measuring Hospitals Service Quality: A Methodological Study", Managing Service Quality, 9(4), pp.230-239.

Coskun Baker and H. Seval Akgun 2008. "The Role of Expectations in Patients' Hospital Assessments", International Journal of Health Care Quality Assurance, 21(5), pp.503-516.

Cronin, J.J., and Taylor, S.A., 1992. "Measuring Service Quality: A Re-examination and Extension", Journal of Marketing, 56(3), pp.55-68.

Dale Fodness and Rrian Murray 2007. "Passengers' Expectations of Airport Service Quality", Journal of Services Marketing, 21(7), pp.492-506.

Daniel Butler, Sharon L. Oswald and Douglas E. Tinner 1996. "The Effects of Demographics of an Determinants of Perceived Health care Service Quality", Journal of management in medicine, 10(6), pp.8-20.

David Walters and Peter Jones, 2001. "Value and Value-Chains in Health care: A Quality Management Perspective", The TQM Magazine, Vol.13, No. 5, pp.319-333.

Dawley, D., Schniederjans, M., Hoffman, J. and Irwin, J., (1999), "Goal Programming and International Expansion in Hospital Industry", Journal of Managerial Issues, Fall, pp.259-279.

Devabakan, N., 2005. "Measurement of Perceived Quality in Health care Organizations", Health Care Management Review, 22 (2), pp.74-89.

Donabedian, A., 1988. "Quality Assessment and Assurance: Unity of Purpose, Diversity of means", Inquiry, 25 (Spring), pp.173-192.

Donald R. Lichtenstein, Scot Burton and G. Netemeyer 1997. "An Examination of Deal Proness Across Sales Promotion Types: A Consumer Segmentation Perspective", Journal of Retailing, 73(2), Summer, pp.283-297.

Dooley. R.S., Fry Kell, G.E and Judge, W.Q 2000. "Belaboring the Non-so-obvious: Consensus, Commitment, and Strategy Implementation Speed and Success", Journal of Management, 36(6), pp: 137-57.

Eaton, S.C., 2000. "Beyond Unloving Care: Linking Human Resource Management and Patient Care Quality in Nursing Homes", International Journal of Human Resource Management, Vol.11, No.3, pp.591-616.

Feldman, R., Hillson, S.D and Winger, T-D 1994. "Measuring the Dimensions of Physician Work," Medical Care, 32(9), pp.943-957.

Ford, R.C., Bach, S.A and Folter, M.D 1997. "Methods of Measuring Patient Satisfaction in Health Care Organizations", Health Care Management Review, 22(2), pp.74-89.

Francis Buttle, 1996. "SERVQUAL: review, critique, research agenda", European Journal of Marketing, Vol.30, No. 1, pp.8-32.

Garman, A.N., Tyler, J.C and Damall, J.S 2005. "Development and Validation of a 360 Degree Feed Back Instrument for Health Care Organization", Journal of Health Care Management, 49(5), pp.307-322.

Gjerde, P.F. and Orishni, M., 2000. "Selves, Cultures, and Nations: The Psychological Imagination of the Japanese in the Era of Globalization", Human Development, 43 (4&5), pp.216-226.

Gnardellis, C and Niakas, D., 2007. "Factors Influencing Impatient Satisfaction: An Analysis Based on the Greek Natural Systems", International Journal of Health Care Technology and Management, 6(3), pp.307-320.

Gronroos, C. 1984. "A Service Quality Model and its Marketing Implications", European Journal of Marketing, vol. 18, No. 4, pp.36-44.

Heistand, M., 1986. "NY Hospitals Treat Marketing-ills?", Adweek, 27(27) July, pp.2.

Jobber D., 2001. Principles and Practices of Marketing, McGraw Hill Publications, England, pp. 231-243.

Kay, M.J 2007. "Healthcare marketing: What is salient?", International Journal of Pharmaceutical and Health Care Marketing,1(3), pp.247-263.

Kelley, S and Davis, M 1994. "Antecedents of Customer Expectations for Service Recovery", Journal of the Academy of Marketing Science, 22(12), pp.52-61

Lam, S.S.K 1997. "SERVQUAL: A Tool for Measuring Patients Opinions of Hospital Service Quality in Hong Kong", Total Quality Management, 8(4), pp.145-152.

Lant, T and Hewlin, P 2002. "Information Cues and Decision-Making: The Effects of Learning, Making: The View from the Black Stool", Organization Science, 6 (3), pp.260-279.

Li-Jen Jessica Hwang, Anita Eves and Terry Desombre, 2003. "Gap Analysis of Patient Meal Service Perceptions", International Journal of Health Care Quality Assurance, Vol.16, No.3, pp.143-153.

Lim, P.C and Tang, N.K.H 2000. "A Study of Patients' Expectations and Satisfaction in Singapore Hospitals", International Journal of Health Care Quality Assurance, 13(7), pp.290-299.

Lin, B., and Kelly, E 1995. "Methodological issues in Patient Satisfaction Surveys", International Journal of Health Care Quality Assurance, 8(6), pp.32-37.

Lynch, J., and Schuler, D., 1990. "Consumer Evaluation of the Quality of Hospital Services from an Economics of Information Perspective," Journal of Health Care Marketing, 10(2), pp.16-22.

Martinez Fuentes, C., 1999. "Measuring Hospital Service Quality: A Methodological Study", Managing Service Quality, 9(4), pp.230-240.

Mayuri Duggirala, Chandrasekharan Rajendran and Anantharaman, R.N., 2008 "Patient – Perceived Dimensions of Total Quality Service in Health Care", Benchmarking: An international Journal, Vol.15, No.5, pp.560-583.

Mosad Zineldin, 2006. "The Quality of Healthcare and Patient Satisfaction", International Journal of Healthcare Quality Assurance, Vol.19, No.1, pp.60-92.

Naceur Jabroum and Mohammed Chaber 2003. "Comparing the Quality of Private and Public Hospitals", Managing Service Quality, 13(4), pp.290-299.

Niakas, D and Mylonakis, J., 2005. "Choice of Physician, Private Payment and Patient Satisfaction. Is there a Relationship?", International Journal of Health Care Technology and Management, 6(3), pp. 288-295.

Niakas, D., Gnardellis, C and Theodorou, M 2004. "Is there a Problem with Quality in the Greek Hospital Sector?, Preliminary Result form a Patient Satisfaction Survey", Health Services Management Research, 17(1), pp.62-69.

Onda, M. Kobayashi, S., Kuroda, K and Zenda, H., 2004. "Factors Influencing Patient Satisfaction with Medication, Counseling and Instructions in Hospitals", Biyoinkanri, 41(1), pp.7-14.

Parasuraman, A, Zeithaml, V and Berry, L. L., 1994. "Reassessment of Expectations as a Comparison Standard in Measuring Service Quality: Implications for Future Research, Journal of Marketing, Vol.58, pp.111-124.

Parasuraman, A., Zeithaml, V.A. and Berry, L.L., 1988. "SERVQUAL: A Multiple-Item Scale for Measuring Customer Perceptions of Service Quality". Journal of Retailing , 64 No.1. pp.12-40.

Puay Cheng Lim and Nelson K.H. Tang, 2000. "A Study of Patients' Expectations and Satisfaction in Singapore Hospitals", International Journal of Healthcare Quality Assurance. Vol.13. No.7, pp.290-299.

Puay Cheng Lim and Nelson, K.H. Tang., 2000. "The Development of a Model for Total Quality Health Care", Managing Service Quality, Vol.10, No.2. pp. 103-111.

Rhian Silvestro, 2005. "Applying Gap Analysis in the Health Services to Inform the Service Improvement Agenda", International Journal of Quality and Reliability Management, Vol.22, No.3, pp.215-233.

Rohini, R., and Mahadevappa, B., 2006. "Service Quality in Bangalore Hospitals–An Empirical Study", Journal of Services Research, 6(1), April-September, pp.59-83.

Rooma Roshnee and Ramsaran Fowdar 2008. "The Relative Importance of Service Dimension in a Health care Setting", International Journal of Health Care Quality Assurance, Vol.21, No.1, pp.104-124.

Sadiq Sohail, 2003. "Service Quality in Hospitals: More Favourable Than You Might Think", Managing Service Quality, 13(3), pp.197-206.

Schultz, P.C., 2005. "Who Should Lead a Health Care Organization: MDs or MBAs?", Journal of Health Care Management, 49 (2), pp.103-116.

Sharma, R.D. and Chahal, Hardeep 1996: A Study of Patients Satisfaction in Outdoor Services of Private Health Care Facilities", Vikalpa, 24, pp.69-76.

Sharma, R.D., and Gupta Mahesh 2004. "Patient Satisfaction in Public Out Patient Health Care Service," The Journal of Health Management, 6(1), pp.23-45.

Shin, J and Moon, S., 2005. "Direct-to-customer Prescription Drug Advertising: Concerns and Consumer's Benefit", The Journal of Consumer Marketing, 22(7), pp.397-403.

Smallwood, S. and Perdenbach, R.E., 1990. "Explaining Perceptions of Hospitals Operations By a Modified SERVQUAL Approach", Journal of Health Care Marketing, 10 (4), pp.47-55.

Smith, A.M., 1995. "Measuring Service Quality: is SERVQUAL Now Redundant?", Journal of Marketing Management, Vol.11, pp.257-276.

Smith, A.M., 1995. "Measuring Service Quality: is SERVQUAL now redundant?" Journal of Marketing Management, Vol. 11, pp.257-76.

Sohail, S.M. 2003. "Service Quality in Hospitals: More Favourable than You Might Think", Managing Service Quality, 13(3), pp.197-206.

Strasser, S., Schweikhart, S., Welch, G.E and Burge, J.C 1995. "Satisfaction with Medical Care", Journal of Health Care Marketing, 15(3), pp.34-43.

Subhasis Ray and Amitara Mukherjee 2007. "Development of a Framework Towards Successful Implementation of e-governance Initiatives in Health care Sector in India", International Journal of Health Care Quality Assurance, Vol.20, No.6, pp.464-483.

Syed Saad Andaleeb 1998. "Determinants of Customer Satisfaction with Hospitals: A Managerial Model", International Journal of Health Care Quality Assurance, 11(6), pp.181-187.

Taner, T. and Antony, J., 2006. "Comparing Public and Private Hospital can Service Quality in Turkey", International Journal of Health Care Quality Assurance, 19(2), pp.1-10.

Tietze, M.F., 2003. "Impact of Managed Care on Health Care Delivery Practices: The Perception of Health Care Administrators and Clinical Practitioners", Journal of Health Care Management, 48 (5), pp.311-321.

Uzun, O., 2001. "Assessment of Patient Satisfaction from Services in a University Hospital in Turkey", Journal of Nursing Care Quality 16(1), pp.24-25.

Valarie. A. Zeithaml, A. Parasuraman and Leonard. L. Berry, 1990. Delivering Quality Service: Balancing Customer Perceptions and Expectations (New York: The Free Press), pp. 147–168.

Vicky Papanikolou and Sypynidonla Netani 2008 "Addressing the Paradoxes of Satisfaction with Hospital Care", International Journal of Health Care Quality Assurance, 21(6), pp.548-561.

Vuori, H., 1991. "Patient Satisfaction–Does it matter?", Quality Assurance Health Care; Vol. 3, pp.183.

Walbridge, S.W. and Delene, Linda, M., 1993. "Measuring Physician Attitudes and Service Quality", Health Care Marketing, 12(2), pp.8-15.

Wilkes, M., Bell, R. and Kravitz, R.C., 2000. "Direct-to-consumer prescription drug advertising: Trends, impact and implications", Health Affairs, 20 (2), pp.110-128.

Winstead, F.K. 2000. "Patient Satisfaction with the Medical Encounters : A Cross Cultural Perspective", International Journal of Industry Management, 11(5), pp.399-421.

Wright, P.C and Grant, E., 1995. "The Strategic Application of TQM Principles to Sales Forces Management: A Human

Resource Perspective", Journal of Marketing, 8(1). pp.8-16.

Yamamoto., T. Yamaki, C.K., Saeki, M and Tamora, M., 2004. "Developing an Instrument for Patient Evaluation of the Quality of Hospital Care", Biyoinkanri 41(1), pp.15-25.

Yezdi, H. Godiwalla and Shirley Y.Godiwalla 2002. "Marketing Issues for Hospital Industry," International Journal of Health Care Quality Assurance, 15(1), pp.25-28.

Youssef, F.N. 1996. "Health Care Quality in NHS Hospitals", International Journal of Health Care Quality Assurance, 17(1), pp.15-26.

Yucelt, U 1994. "An Investigation of Causes of Patient Satisfaction / Dissatisfaction with Physician Services," Health Marketing Quarterly, 12(2), pp.11-28.

Zifko-Baliga, G.M and Krampt, R.K. 1997. "Managing Perceptions of Hospitals Quality", Marketing Health Service, 17(1), pp.28-36.

Zillur Rahman, M.N., Qureshi, 2008. "LIFENET Hospitals (India): Developing New Services-Case Study", International Journal of Health Care Quality Assurance, Vol.21, No.3, pp.274-288.

Zineldin, M., 2000. "Total Relationship Management and Total Quality Management", Managerial Auditing Journal, 15(1-2), pp.20-28.

****