

A Dissertation Report on

An empirical study on marketing initiatives and service quality measures offered thus making a comprehensive economic impact withreference to Indian hospitals.

Submitted in partial fulfillment of the requirements for the degree of

Master of Business Administration (MBA)

by

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Under the Guidance

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DECLARATION

"I, GoutamPanigrahi, hereby declare that this project report entitled " An empirical study on marketing initiatives and service quality measures offered thus making a comprehensive economic impact with reference to Indian hospitals." submitted by me, under the guidance of **Rajeev Kumar Panda, Assistant Professor, School of Management, NIT Rourkela**. Is my own creation and has not been submitted to any other University or Institute or published earlier.

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CERTIFICATE

I, hereby certify that **GoutamPanigrahi**, a student of Masters of Business Administration at School of Management, NIT Rourkela, has completed the project report on “An empirical study on marketing initiatives and service quality measures offered thus making a comprehensive economic impact with reference to Indian hospitals”, under my guidance.

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GoutamPanigrahi

EXECUTIVE SUMMARY

The application of quality-management practices by manufacturers and service providers has become increasingly widespread. Recognition of the differences between manufacturing and services through the dimensions of intangibility, inseparability, and heterogeneity of service products has enabled quality-management practitioners to develop approaches that have proved effective in improving service quality. The quality of service—both technical and functional—is a key ingredient in the success of service organizations). Technical quality in health care is defined primarily on the basis of the technical accuracy of the diagnosis and procedures. Several techniques for measuring technical quality have been proposed and are currently in use in health-care organizations. Information relating to this is not generally available to the public, and remains within the purview of health-care professionals and administrators). In other words, marketing initiatives extends the means to offer additional but relevant products, better and more organized way, to the existing and new customers based on their purchases record. It allows the business to promote similar products with better functionalities that the customer may not be aware of.

This paper has emphasized on the concept of marketing initiatives taken up by hospitals and the service quality that is offered its impact on economic development of the society. From the literature review and my in-hand exploration from both public and private hospitals, some research questions have been taken into consideration for further examination. .How does cross marketing increase customer mobilisation? This paper also tells us about the meaning, existence, types, scope, benefits, limitations of marketing initiatives whether it be the above the line activities or below the line activities that the hospitals are engaged into and also include suggestions to improve the economic development.

This survey was conducted at both the private and public hospitals that is situated in and around Rourkela (Odisha.). The data collection was done from doctors, patients, patient's relatives, patient's friends, hospital staff and marketing officials. Factor analysis has been used to examine the hypothesis and the findings of the survey by using IBM SPSS 2013. All the data were represented a 5 point Likert scale.

The result of the findings was, that the marketing initiatives taken up by hospitals and the service quality thus offered by the hospitals vary from each other and there is no specified model that suggest the exactness put it is seen through the research that the presence of hospitals in society and the extended help from the government with the engagement of various schemes helps patients and other members of the society to engage with this thus resulting in the economic development of the society .

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Chapter -1
Introduction.

1.1 Introduction to Healthcare.

Healthcare is a rare service that people need but do not necessarily want but, remarkably healthcare is the fastest growing service in both developed and developing countries. The traditional services that once dominated the service sector – lodging, foodservice, and housecleaning have been increasingly supplemented by modern banking, insurance, computing, communication, and other business services; and the interest in the measurement of service quality is understandably high in addition to the delivery of higher levels of a service quality strategy being suggested as critical to service providers' efforts in positioning themselves more effectively in the marketplace. Service quality has been revealed as a key factor in search for sustainable competitive advantage, differentiation and excellence in the service sector. Besides, it has been recognized as highly important for satisfying and retaining customers. Accordingly the two questions firstly, ‘What is perceived service quality? And secondly, ‘How must service quality be measured?’ have been debated by academics over the last three decades now and is of utmost interest. Moreover

the ongoing debate on the determinants of service quality and misuse such as ‘Is there a universal set of determinants that determine the service quality across a section of services?’ remains unanswered . Additionally, there is concern for the identification of determinants of service quality. In a consumer-oriented culture where healthcare delivery is patient-led and commoditized, the patient should be the intermediary of the quality of healthcare. Thus the purpose of is to develop a conceptual framework for measuring hospital service quality, expanding the existing models and literature on healthcare services to benefit academicians, practitioners and researchers to enhance the understanding of patient perceived hospital service quality addressing this gap in literature as there are a few reliable and valid instruments available; and many service providers are implementing measures that are not aligned to the complexities of the health care setting . Consequently understanding of service quality assists practitioners to meet the requirements in their daily operations.

Each day, tens of thousands of Indians engage the state’s broad network of healthcare providers for help with improving their individual and family well-being. Hospitals are an important part of this network, providing a variety of accessible acute care services across the country. India is

home to more than 1000 hospitals both including private and public hospitals and health systems. In 2009, these hospitals provided healthcare services for more than 12.9 million patient visits. While hospitals' most important impact is the healthcare services they provide, it is important to recognize that hospitals are also a dynamic part of the economy. In 2011, healthcare sector accounted for 3.87 of Gross Product, a measure of all economic output. The economic activity of hospitals translates into jobs. That's an increase of 9,400 jobs (+15.2 percent) since 2005. The ability of hospitals to continue to provide new employment opportunities to Indians is not a remarkable achievement. The contributions of hospitals to the Indian economy extend far beyond the facilities. Hospitals create thousands of spinoff jobs through their own purchases and those made by their employees with their own incomes. These spin-off jobs are known as the multiplier effect.

1.2. Historical Background

Medicine and surgery date back to the beginning of civilization because diseases preceded humans on earth. Early medical treatment was always identified with religious services and ceremonies. Priests were also physicians or medicine men, ministering to spirits, mind and body, Priests/doctors were part of the ruling class with great political influences and the temple/hospital was also a meeting place.

Medicine as an organized entity first appeared 4000 years ago in the ancient region of Southwest Asia known as Mesopotamia. Between the Tigris and Euphrates rivers, which have their origin in Asia Minor and merge to flow into the Persian Gulf.

The first recorded doctor's prescription came from Sumer in ancient Babylon under the rule of the dynasty of Hammurabi (1728-1686BC). Hammurabi's code of law provides the first record of the regulation of doctors' practice, as well as the regulation of their fees. The Mesopotamian civilization made political, educational, and medical contributions to the later development of the Egyptian, Hebrew, Persian and even Indian cultures.

For Hundreds of years, the Greeks enjoyed the benefits of contact and cross fertilization of ideas with numerous other ancient peoples, especially the Egyptians. Although patients were treated by magic rituals and cures were related to miracles and divine intervention, the Greek recognized

the natural causes of diseases and rational methods of healing were important. Hippocrates is usually considered the personification of the rational non-religious approach to medicine, and in 480 BC, he started to use auscultation, perform surgical operations and provide historians with detailed records of his patients and descriptions of diseases ranging from tuberculosis to ulcers. The temples of Saturn, Hygeia and Aesculapius, the Greek god of medicine all served as both medical schools for practitioners and resting places for patients under observation or treatment.

The Roman talent for organizations did not extend as readily to institutional care of the sick and injured. Although infirmaries for the sick were established, it was only among the military legions that a system for hospitalization was developed. After the injured were cared for in field tents, the soldiers were moved to valetudinarians, a form of hospital erected in all garrisons along the frontiers. Apparently those stone and wooden structures were carefully planned and were stocked with instruments, supplies and medications. The decree of Emperor Constantine in 335 AD closed the Aesculapia and stimulated the building of Christian hospitals. Around 370AD St Basil of Caesarea established a religious foundation in Cappadocia that includes a hospital, an isolation unit for those suffering from leprosy and buildings to house the poor, the elderly and the sick. Following this example similar hospitals were later built in the eastern part of the Roman Empire. Another notable foundation was that of St Benedict at Monte Cassino, founded early in the 6th century, where the care of the sick was placed above and before every other Christian duty. It was from this beginning that one of the first medical schools in Europe ultimately grew at Salerno and was of high repute by the 11th Century. This example led to the establishment of similar monastic infirmaries in the western part of the empire.

The development of efficient hospitals was an outstanding contribution of the Islamic civilization. The Roman military hospitals and the few Christian hospitals were no match for the number, organization and excellence of the Arabic hospitals. The Arab's medical inspiration came largely from the Persian Hospital in Djoundisabour (sixth century Turkey), at which many of them studied. Returning to their homes, they founded institutions that were remarkable for the times. During the time of Mohammed, a real system of hospitals was developed. He was the first to order the establishment of small mobile military Bimaristan (hospital) .Asylums for the insane were founded ten centuries before they first appeared in Europe. In addition, Islamic physicians

were responsible for the establishment of Pharmacy and chemistry as sciences. Some of the best known of the great hospitals in the middle Ages were in Baghdad, Damascus and Cairo. In particular, the hospitals and medical schools of Damascus had elegant rooms, an extensive library and a great reputation for its cuisine. Separate wards were set aside for different diseases, such as fever, eye conditions, diarrhea, wounds and gynecological disorders. Convalescing patients were separated from sicker patients and provisions were made for ambulatory patients. Clinical reports of cases were collected and used for teaching.

Indian Hospitals: Historical records show that efficient hospitals were constructed in India by 600 BC. During the splendid reign of King Asoka (273-232 BC), Indian hospitals started to look like modern hospitals. They followed principles of sanitation and cesarean sections were performed with close attention to technique in order to save both mother and child. Physicians were appointed –one for every ten villages-to serve the health care needs of the populations and regional hospitals for the infirm and destitute were built by Buddha.

The middle Ages: Religion continued to be the dominant influence in the establishment of hospitals during the middle age. From the early fourth century to the fifteenth century trade was almost totally suppressed and many city dwellers returned to the land. Religious communities assumed responsibility for care of the sick .The rational nonreligious approach that characterized Greek medicine during the era of Hippocrates was lost, as hospitals became ecclesiastical, not medical institutions. Only the hopeless and homeless found their way to these hospitals, in which the system of separation of patients by diseases was eliminated, three to five patients were accommodated in each bed and principles of sanitation were ignored. Surgery was avoided, with the exception of amputation, in order not to “disturb the body” and to avoid the shedding of blood per the church edict of 1163 that, in effect, forbade the clergy from performing operations. Religious order emphasized nursing care, the first religious order devoted solely to nursing is considered to be the St Augustine nuns, organized in approximately 1155.

Yet hospital construction increased in Europe during the middle Ages for two reasons. First, Pope Innocent III in 1198 urged wealthy Christians to build hospitals in every town and second, increased revenues were available from the commerce with the crusaders. The oldest hospital

still in existence are the “Hotel –Dieu” in Lyons and Paris, France. The term “Hotel-Dieu” indicates that it is a public hospital. The earliest mention of the Hotel –Dieu in Lyons is found in a manuscript of 580 AD, in which its establishment by Childebert is recorded. The Hotel-Dieu of Paris was founded by Bishop Landry in 660, on the LLe de la Cite. In 1300, the hospital had an attending staff of physicians and surgeons caring for 800-900 patients, and its capacity was doubled in the fifteenth century. In these hospitals more attention was given to the wellbeing of the patient’s soul than to curing bodily ailments. The growth of hospitals accelerated during the crusades, which began at the end of the 11th century. Pestilence and disease were more potent enemies than the Saracens in defeating the crusaders. Military hospitals came into being along the traveled routes: the knights Hospitalist of the Order of St John in 1099 established in the Holy Land, a hospital that could care for some 2000 patients. It is said to have been especially concerned with eye disease and may have been the first of the specialized hospitals. This order has survived through the centuries as the St John’s Ambulance Corps.

In contrast, in Asia and Africa, during the same period, construction of effective and efficient hospitals was spurred by Islamic rule and the Crusades. The two hospital systems enforced sanitary measures ,performed surgery and separated patients according to disease: the Islamic hospitals because theywere still following the Greek and early Roman traditions, and the hospitals created by the Crusaders because injuries sustained in combat necessitated surgery and the presence of pests and contagious disease necessitated sanitary conditions and the strict separation of patients. For the first time, medical systems of the East and the West vied for the supremacy of medical care. Arab hospitals were notable for the fact that they admitted patients regardless of religious belief, race or social order.

Renaissance Age: The renaissance period lasted from the fourteenth to the sixteenth centuries. It received its name from the Italian “rinascita” meaning rebirth, because of the common belief that it embodies a return to the cultural priorities of ancient Rome and Greece. The healing arts were again characterized by a scientific, rational approach. The period also saw the beginnings of support for hospital like institutions by secular authorities. Toward the end of the 15th century many cities and towns supported some kind of institutional healthcare: it has been said that in England there were no less than 200 such establishments that met a growing social need. The

gradual transfer of responsibility for institutional healthcare from the church to civil authorities continued in Europe after the dissolution of the monasteries in 1540 by Henry VIII, which put an end to hospital building in England for some 200 years. Only the powerful hospitals in London survived when the citizens petitioned the King to endow St Bartholomew, St Thomas and St Mary of Bethlehem hospitals. This was the first instance of secular support of hospitals.

The loss of monastic hospitals in England caused the secular authorities to provide for the sick, the injured and the handicapped, thus laying the foundation for the voluntary hospital movement. The first voluntary hospital in England was probably established in 1718 by Huguenots from France and was closely followed by the foundation of such London hospitals as the Westminster hospital in 1719, Guy's hospital in 1724 and the London Hospital in 1740. Between 1736 and 1787 hospitals were established outside London in at least 18 cities. The initiative spread to Scotland where the first voluntary hospital, the little Hospital, was opened in Edinburgh in 1729.

If the middle ages can be seen as the period of the great hospitals, the renaissance was really the period of the great school of medicine. Schools of medicine flourished in Germany and in central and eastern Europe. The scientific study of human anatomy as a science were facilitated by dissections of animals. In 1506, the Royal College of Surgeons was organized in England, followed by organization of the Royal College of Physicians in 1528. The major contribution of the Renaissance to the development of hospitals was in improved management of the hospital, the return to the segregation of patients by disease, and the higher quality of medicine provided within the hospital. Clinical surgery took great strides during this period, not only in Italy but also in France, especially under Ambrose Pare, who introduced the ancient methods of stopping hemorrhage by using ligatures and abandoned the barbaric system of cauterizing irons. The academic world of northern Italy was tolerant of new cosmopolitan ideas. By the mid fifteenth century, all major courts and cities of Europe sent their finest physicians to Italy for advanced training.

New World: The first hospitals of the New World were built in colonies of Spain, France and England. Those built under the flags of Catholic Spain and France retained the ideals of the

Jesuits, the Sisters of Charity and the Augustine Sisters and their hundreds of years of hospital knowledge. Hospitals built in the English colonies, however, reacted against English traditions.

The first hospital in the New World was constructed as part of a system for the occupation of overseas territories. Bartholomew de las Casas, one of the priests who accompanied Columbus on his first voyage and a well-known historian referred to the founding of the village of La Isabella in Hispaniola (today, Santo Domingo), in January of 1494: "Columbus made haste in constructing a house to keep supplies and the ammunition for the soldiers, a church and a hospital". No further information survives to indicate whether the hospital was actually built.

The first hospital in North America was built in Mexico City in 1524 by Cortes: the structure still stands. The French established a hospital in Canada in 1639 at Quebec City, the Hotel Dieu du Precieux Sang, which is still in operation although not at its original location. In 1644 Jeanne Mance, a French noblewoman, built a hospital of ax-hewn logs on the island of Montreal; this was the beginning of the Hotel Dieu de St Joseph, out of which grew the order of the Sisters of St Joseph, now considered to be the oldest nursing group organized in North America. The first hospital in the territory of the present day United States is said to have been a hospital for soldiers on Manhattan Islands, established in 1663. The early hospitals were primarily almshouses, one of the first of which was established by William Penn in Philadelphia in 1713. The first incorporated hospital in America was the Pennsylvania Hospital, in Philadelphia, which obtained the charter from the crown in 1751. According to an inscription on its wall, the institution intended to foster patient's self-respect and remove any stigma from a hospital visit by charging fees. Benjamin Franklin helped to design the hospital, which was built to provide a place for Philadelphia physicians to hospitalize their private patients. Franklin served as president from 1755 to 1757.

In another break from tradition the New York hospital was founded in 1771 by private citizens who formed the Society of the New York hospital and obtained a grant to build it. The hospital was characterized by a spirit of learning and research. As with other hospitals founded before the era of large fortunes, the New York hospital was built on the contribution of small merchants and farmers.

Another innovation was the first hospital conducted only by women. The New York Infirmary for Women and Children was opened in 1853 by the first woman to earn a medical degree in the United States, Elizabeth Blackwell and her sister. Again, this is another example of a private owned hospital that was founded to accommodate physician's needs.

The European and Latin American tradition of charity hospitals, based on love of God and neighbors and the conviction that the government owed a responsibility to helpless citizens was never a part of the US hospital traditions. As a result, a more competitive system of hospitals developed, with fewer subsidies and less involvement of religious organizations in total healthcare. Massive government involvement in healthcare began in 1926 with the return of veterans from World War I.

Chapter -2

Industry Profile.

2.1 Brief History.

In between the 1950's and 1980's the Health care facilities and personnel increased substantially, but gradually due to the fast population growth, the number of licensed medical practitioners per 10,000 individuals had fallen in the 1980's to 3 per 10,000 from the 1981 level of 4 per 10,000. There were approximately ten hospital beds per 10,000 individuals in 1991. Primary health centers are majorly the cornerstone of the rural health care system.

In the year 1991, India constituted about 22,400 primary health centers, 11200 hospitals, and 27,400 dispensaries. Such facilities were the part of a tiered health care system which funnels more difficult cases into urban hospitals while attempting to provide routine medical care to the vast majority in the countryside. Primary health centers and sub-centers would majorly rely on trained paramedics to meet most of their needs.

Indian healthcare industry operates in both of the private and public sectors. The public sectors are healthcare system consists of facilities run by the central and state governments. The facilities are provided freely or at subsidized rates to lower income families in rural and urban areas. However, further the Indian healthcare industry is going through a growth phase due to its healthy economy. As the country's middle class continues to grow this industry's growth will increase. India's ever-growing middle class are able to afford quality healthcare. With such an increased ability to pay for better healthcare, the demand for healthcare services has grown from \$4.8 billion in 1991 to \$22.8 billion in 2001-2002. Today 50 million Indians are able to afford western medicine and over 150 million have annual incomes of more than 1000 US dollars.

Indian health care industry growth story is moving ahead neck to neck with the pharmaceutical industry & the software industry of the nation. There has been much done in the health care sector for bringing the improvement like till date, approximately 12% of the scope offered by the industry has been tapped. In the years to come the health care industry in India is reckoned to be the engine of the Indian economy. Today the Health care industry in India is worth \$17 billion and there are anticipation & expectation of it to grow by 13% every year. The health care sector consists of health care instruments, health care in the retail market, hospitals enrolled to the hospital networks. etc.

Indian healthcare Industries include systems like Ayurveda and homeopathy which are increasingly gaining prominence overseas. Another major area for investment in India is the research industry of the Health Care. In India there are tremendous prospects with a huge talent pool and the rise of biotechnology and bioinformatics. India is a rising and expanding destination for medical tourism. With affordable medical expenses and a sound technology in place goes good with the growing sector which would be bode well for the healthcare industry in India.

2.2 Size of the industry

Indian healthcare industry comprises of hospitals and allied sectors which is projected to grow 23 % per annum to touch US\$ 77 billion by 2012 and according to the current estimated size of US\$ 35 billion. The Industry has registered a growth of 9.3 % between 2000-2009, as compared to the sectoral growth rate of emerging economies such as China, Brazil and Mexico. There would be increase in number of public and private healthcare facilities which are expected to propel demand for the industry, accounting for another US\$ 6.7 billion.

2.3 Total contribution to the economy/ sales

Indian Government Expenditure on health care is the highest amongst all the developing countries. The expenses of this industry comprise 5.25% of the GDP. There are even chances that the health care market could experience a hike and attain a figure ranging between \$53 to \$73 billion five years later. Which would in turn reflect an increase in the gross domestic product to 6.2%? The Indian Health Care Industry earns revenues accounting for 5.2% of gross domestic product.

2.4 Top leading Players

Private players have made significant investments in setting up of the private hospitals in cities like Mumbai, New Delhi, Chennai and Hyderabad. There is emergence of latest medical technology and have created a competitive environment. The government's share in the healthcare delivery Industry is 20 % while 80 % is in the private sector. The Emergence of corporate hospitals has led

to increased professionalism in medical practices and use of hospital management tools.

- Apollo Group
- Fortis
- Max
- Wockhardt
- Duncan
- Ispat
- Escorts
- Medanta
- Tata

2.5 Employment opportunities

Indian Health Care Industry provides employment opportunities to as many as 4 million people in the health care segment or other related sectors catering to the needs of the medication. India has become one of the favorite for health care treatments which is owing to the vast differences in medical expenses in western countries. Due to the Indian progressive nature of the health care sector several foreign companies are intending to even invest in the country. Health Care jobs are considered to be one among of the most noble career options which is known to be the single largest profession all around the world.

There are numerous medical complexities and the need for advanced medical care have necessitated the recruitment of qualified and experienced medical professionals in this field such as doctors, physicians, medical assistants, radiologists, cardiologists, anesthesiologists, and surgeons. There are immense

opportunities for Doctors, Resident Doctors, Surgeons, Physicians, and Physical Therapists & Dentists. Vital information on Hospitals are provided by employment agencies who help people register as healthcare workers, Medical recruiting agencies, travel & resettlement agencies and local recruiting.

2.6 Latest developments

As per the Department of Industrial Policy and Promotion (DIPP), the drugs and pharmaceuticals sector has attracted FDI worth US\$ 1.70 billion between from the year 2000 to the year 2010, while hospitals and diagnostic centres have received FDI worth US\$ 786.14 million in the same period.

- Majorly the Indian Health Care Industry and Fortis Hospitals plans to invest US\$ 53.7 million and plans to expand the facilities for the pan-India.
- Columbia Asia Group, which already has six hospitals in the country- Asia's leading hospital chain, plans to ramp-up its operations in India by opening eight more multi-speciality community hospitals with a total capacity of 800 beds by the year of mid-2012. The total investment of US\$ 177.1 million for the 14 hospitals.
- In Hyderabad, the Narayana Hrudayalaya has inaugurated the phase-I of the 5,000-bed health city which is the Hub for the multinational corporations. The company plans to expand its presence to seven more cities to take the total number of hospitals to 14 in the next 2-3 years.
- Cochlear Ltd plans an Australian medical devices company to set up its wholly-owned subsidiary in India, to provide better patient and product support. In next five years the Company also plans to invest about US\$ 15 million.

2.7 Government Initiatives

National Rural Health Mission (NRHM) has been launched in the year 2005 by the Government. The main aim is to provide quality healthcare for all and there would be an increase in the expenditure on healthcare from 0.9 % of GDP to 2-3 % of GDP by 2012. According to Union Budget 2010-11 there is an increased allocation for Ministry of Health and Family Welfare from US\$ 4.2 billion in 2009-10 to US\$ 4.8 billion in 2010-11.

- The priority of strengthening the PHCs for 24x7- today reported by the States there are 8,755 24x7 PHCs having three nurses each by the government system.
- In the last two-and-a-half years there are more than 50 lakh women who have been brought under the JananiSurakshaYojana (JSY) for good institutional deliveries.
- There are 4,380 para medical staff having been appointed on contract and 6,232 doctors, 2,282 specialists, 11,537 staff nurses appointed on contract in the States which could reduce the human resource gaps in many institutions.
- IPH standards have been finalized and a first grant of Rs. 20 lakh was made available to all the District Hospitals in the country to improve their basic services, given the increased patient load due to JSY and other programmers.

Chapter -3
Literature Review.

3.1 Marketing Initiatives

Perhaps, because the target of B2B marketing is very narrow, previous studies on B2B marketing focused on the relationship between buyers and sellers, or manufacturers and distributors at the exclusion of any other relationships such as the relationship between sellers and the other stakeholders of the corporation, or the corporate public. Ford (1980) in one of the very early studies on the buyer seller relationships examines the evolution of the relationship in industrial markets and concludes that the relationship is a process that develops over time, and occurs in five different stages. From an initial pre-relationship stage, the process evolves through three other stages before reaching the final fifth stage. This stage is characterized by an extension of the institutionalization process where “the conduct of business is based on industry codes of practice” (Ford, 1980, p. 349).

The author concludes the study with one observation, that is, each of the five different stages in the evolution of the buyer seller relationship has “different variables of experience, uncertainty, distance, and commitment.” Thus, he advises Companies not to treat the market as the same, instead they should realize that the market is segmented, and regard it rather as a network of relationships. Anderson et al. (1994) argue the importance in understanding the dyadic relationships that take place between firms, and emphasize the need to examine the “embedded context within which dyadic business relationships take place” (Anderson et al., 1994, p. 1). 1984; Pfeffer, 1987; Pfeffer and Salancik, 1978), Anderson et al. (1994) posit that inter-firm relationships are formed around three principal factors: actors, resources, and activities, and provide a means whereby the interconnectedness that exists within the dyadic relationships could be understood. This study provides a comprehensive review of B2B relationships and makes several references to the role of service providers in the value addition- chain processes. However, there is still a knowledge gap with regard to the relationship between sellers and buyers of intangible goods or pure services.

3.2 Service Quality.

Various researchers have developed alternate concepts for service quality, like the Nordic view (Gronroos, 1984) and the American view (Parasuraman et al., 1988). The Nordic view explains the service quality on two dimensions, i.e. functional and technical quality. The American view defines service quality on five dimensions – tangibility, empathy, assurance, reliability, and responsiveness. Subsequently, a three dimensional concept of service quality was developed by Rust and Oliver (1994). The three dimensions were service product, service environment and service delivery. Parasuraman et al. (1988) defined service quality as the gap between customers' expectations of service and their perception of the service experience. They proposed SERVQUAL framework to assess perceived service quality for variety of sectors. The SERVQUAL framework has been applied to number of sectors like retail store (Dabholkar et al., 1996); hotel (Ingram and Daskalakis, 1999); logistics service quality (Mentzer et al., 2001); banks (Bahia and Nantel, 2000) and Spanish public services like university and hospital (Bigne et al., 2003) for assessing perceived service quality. As patients are often unable to assess the technical quality of medical services accurately and as these services are dominant in credence qualities (Zeithaml and Bitner, 2003), functional quality is usually the primary determinant of patients' perceptions of

quality (Donabedian, 1980). There is growing evidence to suggest that this perceived quality is the single most important variable influencing consumers' perceptions of value, and that this, in turn, affects their intention to purchase products or services (Bolton and Drew, 1988; Zeithaml et al., 1996). The world health organisation (Wilkinson et al., 2004) defined quality of healthcare through benchmarks of efficiency, cost effectiveness, and social acceptability. In the concept of social acceptability, the patient's perspective is clearly highlighted (Sajid and Baig, 2007). By measuring mortality and morbidity, a healthsystem can only provide unilateral assessment of its competency.

Carman (1990) through a study of acute care hospitals identified admission, tangibles accommodation, tangible food, tangible privacy, nursing, explanation visitor access, courtesy, discharge planning, and patient accounting as dimensions explaining perceived service quality for hospitals. Baltussen et al. (2002) proposed health personnel practices and conduct, adequacy of resources and services, healthcare delivery, financial, and physical accessibility of care as dimensions underlying the construct of perceived service quality for hospitals in a study

conducted in Burkina Faso. Despite the practical difficulties in obtaining information on customer expectations, many studies continue to use the “gap model.” Such model facilitates the identification of strengths and weaknesses in specific quality attribute (Ladhari, 2008). Hence, the “gap model” of service quality has been adopted for the present research. Borrowing from Carman (1990) and Rust and Oliver’s (1994) three dimensions, the dimensions included in the instrument are admission, medical service, overall service, and discharge. The dimension social responsibility is relevant as a part of the GDP (during the last five years the average spending in health was 0.86 percent of the GDP) is allocated by the government on public healthcare; informal payments are a part and parcel of the delivery system; the government health subsidy does not reach the actual beneficiaries; there is lack of accountability and 70 percent of the urban households and 63 percent of the rural households resort to the private sector as the chief source of healthcare (National Family Health Surveys, 2005-2006).

Given this, it can be a challenge for health organizations to deliver a satisfactory service to receivers in such states of mind. In service organizations, mood states have direct and indirect effects on customers’ behavior, ability to evaluate and their recall (Gardner, 1985). Emotions experienced during service encounters (Shostack, 1985; Bitner et al., 1990) are related to perceived satisfaction with the service itself (Liljander and Strandvik, 1997)[1]. What the patient sees, hears, feels, smells and tastes contributes to the building of his or her perception about the health service as well as have an impact on service co-creation (Gill et al., 2011a). public service as the health service would be able to make use of an approach already tried in the commercial field to influence customers’ mood, perceptions and behavior positively by acting on the five senses – “sensory marketing”. This approach, which has been largely ignored outside of retailing, consists of using sensory triggers to involve the buyer’s basic senses (Hultén et al., 2009; Krishna, 2012). For example, it has been demonstrated that the diffusion of fragrances and perfumes in a retail area can lengthen the time a potential buyers will stay there, with positive effects on impulse purchasing, just as certain kinds of music played through supermarket shelves may guide buyers to choose one product over another (Bateson and Hoffmann, 1999; Nasermodeli et al., 2013).

3.3 Economic Development

According to the “shareholder model” or “profit-centered model” of corporate governance, businesses are ultimately if not uniquely accountable to their owners (Berle and Means, 1968). The proponents of a “stakeholder model” or “social responsibility model”, however, explain that businesses are accountable to everyone (whether individuals or groups of individuals or society as a whole) who has a stake in their activity (Halal, 2000). In the era of privatization, liberalization and globalization, it is imperative to examine the various expectations of stakeholders, as they play a critical role at economic, social, cultural and political levels (Stevens, 1991). A wide range of influences, decisions and policies affect hospitals. When examining the hospital – stakeholder relationships since the 1950s, one can conclude that “the number and diversity of stakeholder groups and their power vis-a` -vis the health care organizations have increased, but the level of their support has decreased” (Fottler et al., 1989). This suggests that stakeholder management is becoming of even more critical importance for hospital managers, and that they need to assess stakeholders’ power and to identify the sources of that power and the core underlying values. Hence, the development of various proactive tool kits or models aimed at helping managers map the key stakeholders, link them to critical issues, and clearly delineate managerial responsibilities for stakeholder management (Fottler et al., 1989). Also there is the emphasis of the skills a good manager ought to master if he or she wants to lead a successful negotiation with potentially threatening stakeholders (Blair et al., 1989).

Chapter -4

Objectives and scope of the project.

4.1 OBJECTIVE OF THE PROJECT

GENERAL OBJECTIVES

1. To find whether hospitals are making considerable marketing initiatives in educating and informing customers about their services offered.
2. To measure and build a relationship between the factors defined in SERVQUAL scale in hospitals and their impact.
3. To find whether hospitals are fulfilling their social obligations in terms of socio-economic responsibilities of that power and the core underlying values.

4.2 Hypothesis

The following hypothesis will be tested:

➤ **H1**

- H1a- Marketing initiatives are considerably helping customers to gain information about the services offered in the hospitals.
- H1b- Marketing initiatives are considerably not helping customers to gain information about the services offered in the hospitals.

➤

➤ **H2**

- H2a- There is a considerable economic impact by the service quality offered by Indian hospitals
- H2b- . There is no considerable economic impact by the service quality offered by Indian hospitals

4.3 Need for present study.

Today globalization and liberalization are affecting economies of not only developing but also developed countries. The focus areas for organizations are also changing from profit maximization to maximizing profits through increased customer satisfaction. The pressures of competition are forcing the organizations to not only look on the processes but also on the way they are delivered. During past two decades business scenario has changed drastically. Some of the key changes that have taken place in the business are:

- Horizontal business processes replacing vertical functional approach.
- Greater sharing of information with all connected links and customers.
- Greater emphasis on organizational and process flexibility.
- Necessity to coordinate processes across many sites.
- Employee empowerment and the need for rules-based real time decision support systems.
- Competitive pressure to introduce new service/products more quickly.
- Integrated customer driven processes.
- Quick response to customer's needs.
- Worldwide relationships between various trade partners, suppliers etc.
- Easily accessible information through internet.
- Flexible and efficient service/product customization.

Owing to the factors like opening up of markets, increase in use of IT, increased customer knowledge and awareness etc., it becomes a must to deliver the services better than its competitor at agreed price. In this context, the subject of service quality needs a fresh understanding in the current business scenario. This study can help to identify the research gaps and thus attempts to provide benefits to practicing managers.

Chapter-5
Research Methodology.

5.1 RESEARCH METHODOLOGY

Research methodology is the process of studying problems whose solutions are to be derived partly or wholly from facts. These facts may be statements of opinions, historical facts, those contained in records and reports, the results of tests, answers of questionnaires, experimental data of any sort, and so forth. The research methodology defines what the activity of research is, how to proceed, how to measure progress, and what constitutes success. It provides us an advancement of wealth of human knowledge, tools of the trade to carry out research, tools to look at things in life objectively; develops a critical and scientific attitude, disciplined thinking to observe objectively (scientific deduction and inductive thinking); skills of research particularly in the age of information. The research methodology is a science that studies how research is done scientifically. It is the way to systematically solve the research problem by logically adopting various steps. Also it defines the way in which the data are collected in research project.

5.2 TYPES OF RESEARCH METHODOLOGIES

1. QUALITATIVE

This type of research methods involve describing in details specific situation using research tools like interviews, surveys, and Observations. It focuses on gathering of mainly verbal data rather than measurements.

2. DESCRIPTIVE/QUANTITATIVE

This type of research methods requires quantifiable data involving numerical and statistical explanations. Quantitative analysis hinges on researchers understanding the assumptions inherent within different statistical models. It generates numerical data or information that can be converted into numbers. The presentation of data is through tables containing data in the form of numbers and statistics.

3. CORRELATION/REGRESSION ANALYSIS

This research methodology involves determining the strength of the relationship between two or more variables.

4. QUASI-EXPERIMENTAL

This research involves the comparison of two groups, one which is influenced by an external source and another which is not.

5. EXPERIMENTAL

Use of random assignment to place participants in two groups: an experimental group which receives intervention, and another control group without any intervention. It is using a positive control for you to base it or compare it in your result.

6 .META-ANALYSIS

This research method is useful for finding out the average impact of several different studies on a hypothesis.

5.3 TYPE OF RESEARCH METHODOLOGY USED

Qualitative research methodology is used in this research. It is a method of inquiry employed in many different disciplines, traditionally in the social sciences, but also in market research and further contexts. **Quantitative research** is the systematic empirical investigation of observable phenomena via statistical, mathematical or numerical data or computational techniques. The objective of quantitative research is to develop and employ mathematical models, theories and/or hypotheses pertaining to phenomena. The process of measurement is central to quantitative research because it provides the fundamental connection between empirical observation and mathematical expression of quantitative relationships. Quantitative data is any data that is in numerical form such as statistics, percentages, etc.^[1] In layman's terms, this means that the quantitative researcher asks a specific, narrow question and collects a sample of numerical data from observable phenomena or from study participants to answer the question. The researcher analyzes the data with the help of statistics. The researcher is hoping the numbers will yield an unbiased result that can be generalized to some larger population.

5.4 DATA COLLECTION

Data collection is one of the central part of the research activities. There are two main categories of market research data: primary data and secondary data. Primary data are collected for the first time by either one or blend of:

1. Observation
2. Questionnaires
3. Experimentation

Secondary data is the existing information that may be useful for the purpose of specific surveys. It can be collected from either journals, books, researchers or institutions etc. Here in this study both primary and secondary sources of data are used. To come up with the sales of the product, questionnaire has been prepared and responses, feedbacks are recorded. This was collected for the first time and thus primary data has been used. Data was also gathered from the information collected from the people associated with the company which they belonged to supply, manufacturing and production, global strategy or distribution and marketing divisions within the firms. These operations divisions were selected because of their relevance to providing data specific to supply chain strategies. Marketing is also significant because of its ability to influence supply chain divisions. The personnel were from positions ranging from level 1 to upper management.

Additional information was also obtained through the form of analyst and annual reports as well as literature and internet resources suggested by the interviewees. Literature and internet resources were used to a lesser extent compared to the data directly obtained from the interviews. In a structured interview, the researcher asks a standard set of questions and nothing more.

1. FACE -TO -FACE INTERVIEWS: It has a distinct advantage of enabling the researcher to establish rapport with potential participants and therefore gain their cooperation. These interviews yield highest response rates in survey research. They also allow the researcher to clarify ambiguous answers and when appropriate, seek follow-up information. Disadvantages include impractical when large samples are involved time consuming and expensive.

2. TELEPHONE INTERVIEWS: These are less time consuming and less expensive and the researcher has ready access to anyone on the planet who has a telephone. Disadvantages are that the response rate is not as high as the face-to- face interview as but considerably higher than the mailed questionnaire. The sample may be biased to the extent that people without phones are part of the population about whom the researcher wants to draw inferences.

3. COMPUTER ASSISTED PERSONAL INTERVIEWING (CAPI): It is a form of personal interviewing, but instead of completing a questionnaire, the interviewer brings along a laptop or hand-held computer to enter the information directly into the database. This method saves time involved in processing the data, as well as saving the interviewer

from carrying around hundreds of questionnaires. However, this type of data collection method can be expensive to set up and requires that interviewers have computer and typing skills.

5.5 UNSTRUCTURED INTERVIEW

In this research, Unstructured Interview method is used to interview the participants. Because Unstructured interviews have the most relaxed rules. In this type, researchers need only a checklist of topics to be covered during the interview. There is no order and no script. The interaction between the participant and the researcher is more like a conversation than an interview. Unstructured interviews are most often used in ethnographies and case studies (types of qualitative studies). They are best used when researchers want to find as much information as possible about their topic. The benefit is that unstructured interviews often uncover information that would not have been exposed using structured or semi-structured interviews. The researcher and participant are not limited by the protocol.

5.6 SAMPLING METHODS

Sampling methods are classified as either probability or non-probability. In probability samples, each member of the population has a known non-zero probability of being selected. Probability methods include random sampling, systematic sampling, and stratified sampling. In non-probability sampling, members are selected from the population in some non-random manner. These include convenience sampling, judgment sampling, quota sampling, and snowball sampling. The advantage of probability sampling is that sampling error can be calculated. Sampling error is the degree to which a sample might differ from the population. When inferring to the population, results are reported plus or minus the sampling error. In non-probability sampling, the degree to which the sample differs from the population remains unknown.

1. **RANDOM SAMPLING** is the purest form of probability sampling. Each member of the population has an equal and known chance of being selected. When there are very large populations, it is often difficult or impossible to identify every member of the population, so the pool of available subjects becomes biased.

2. **SYSTEMATIC SAMPLING** is often used instead of random sampling. It is also called an nth name selection technique. After the required sample size has been calculated, every nth record is selected from a list of population members. As long as the list does not contain any

hidden order, this sampling method is as good as the random sampling method. Its only advantage over the random sampling technique is simplicity. Systematic sampling is frequently used to select a specified number of records from a computer file.

3. **STRATIFIED SAMPLING** is commonly used probability method that is superior to random sampling because it reduces sampling error. A stratum is a subset of the population that shares at least one common characteristic. Examples of strata might be males and females, or managers and non-managers. The researcher first identifies the relevant strata and their actual representation in the population. Random sampling is then used to select a sufficient number of subjects from each stratum. "Sufficient" refers to a sample size large enough for us to be reasonably confident that the stratum represents the population. Stratified sampling is often used when one or more of the strata in the population have a low incidence relative to the other strata.

4. **CONVENIENCE SAMPLING** is used in exploratory research where the researcher is interested in getting an inexpensive approximation of the truth. As the name implies, the sample is selected because they are convenient. This non-probability method is often used during preliminary research efforts to get a gross estimate of the results, without incurring the cost or time required to select a random sample.

5. **JUDGMENT SAMPLING** is a common non-probability method. The researcher selects the sample based on judgment. This is usually an extension of convenience sampling. For example, a researcher may decide to draw the entire sample from one "representative" city, even though the population includes all cities. When using this method, the researcher must be confident that the chosen sample is truly representative of the entire population.

6. **QUOTA SAMPLING** is the non-probability equivalent of stratified sampling. Like stratified sampling, the researcher first identifies the strata and their proportions as they are represented in the population. Then convenience or judgment sampling is used to select the required number of subjects from each stratum. This differs from stratified sampling, where the strata are filled by random sampling.

7. **SNOWBALL SAMPLING** is a special non-probability method used when the desired sample characteristic is rare. It may be extremely difficult or cost prohibitive to locate respondents in these situations. Snowball sampling relies on referrals from initial subjects to generate additional

subjects. While this technique can dramatically lower search costs, it comes at the expense of introducing bias because the technique itself reduces the likelihood that the sample will represent a good cross section from the population.

5.7 SAMPLING METHOD USED

In this research, simple random sampling is used. Simple random sample is a subset of individuals (a sample) chosen from a larger set (a population). Each individual is chosen randomly and entirely by chance, such that each individual has the same probability of being chosen at any stage during the sampling process, and each subset of k individuals has the same probability of being chosen for the sample as any other subset of k individuals. This process and technique is known as simple random sampling, and should not be confused with systematic random sampling. A simple random sample is an unbiased surveying technique.

Chapter – 6
Data Analysis and Interpretation.

6.1 RESEARCH PHASES

The entire research was carried out in three planned phases, which worked as the framework upon which the research was carried out.

The phases are mentioned below.

1. Planning
2. Design
3. Data collection
4. Statistical analysis.

6.2 PLANNING

Since the project involved collecting data from different branches under the Zonal office and from the zonal office itself the first and foremost task was to select the officers who are involved in both marketing and selling of products to customers.,

6.3 DESIGN

The project adopted collecting data with the help of a well-structured questionnaire, one to one interviews in some cases.

6.4 Data Collection.

In quantitative research, we collect numerical data. This is closely connected to the final part of the definition: analysis using mathematically based methods. In order to be able to use mathematically based methods, our data have to be in numerical form. This is not the case for qualitative Research. Qualitative data are not necessarily or usually numerical, and therefore cannot be analyzed by using statistics. Therefore, as quantitative research is essentially about collecting numerical data to explain a particular phenomenon, particular questions seem immediately suited to being answered using quantitative methods. Does this not severely limit the usefulness of quantitative research though? There are many phenomena we might want to look at, but which don't seem to produce any quantitative data. In fact, relatively few phenomena in education actually occur in the form of 'naturally' quantitative data. Luckily, we are far less limited than might appear from the above. Many data that do not naturally appear in quantitative form can be collected in a quantitative way. We do this by designing research instruments aimed specifically at converting phenomena that don't naturally exist in quantitative form into quantitative data, which we can analyze statistically. Data was collected through questionnaire

and Likert 5 point scale was being used. A **Likert scale** is a psychometric scale commonly involved in research that employs questionnaires. It is the most widely used approach to scaling responses in survey research, such that the term is often used interchangeably with *rating scale*, or more accurately the **Likert-type scale**, even though the two are not synonymous.

The format of a typical five-level Likert item.

1. Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree

6.5 LIMITATIONS

There were some limitations which have made my work a little bit harder. The limitations may be termed as follows:

- 1) Poor connectivity to the different place in my research area
- 2) Poor condition of the road service to different place.
- 3) Unwillingness to share the response of the branch managers or the marketing officials.

6.6 Data Analysis.

6.6.1 Reliability

In statistics, **Cronbach's α (alpha)** is a coefficient of internal consistency. It is commonly used as an estimate of the reliability of a psychometric test for a sample of examinees. It was first named alpha by Lee Cronbach in 1951, as he had intended to continue with further coefficients. The measure can be viewed as an extension of the Kuder–Richardson n statistics, **Cronbach's α (alpha)**^[1] is a coefficient of internal consistency. It is commonly used as an estimate of the reliability of a psychometric test for a sample of examinees. It was first named alpha by Lee Cronbach in 1951, as he had intended to continue with further coefficients. The measure can be viewed as an extension of the Kuder–Richardson Formula 20 (KR-20), which is an equivalent measure for dichotomous items. Formula 20 (KR-20), which is an equivalent measure for dichotomous items.

Cronbach's alpha also has a theoretical relation with factor analysis. As shown by Zinbarg, Revelle, Yovel and Li,^[14] alpha may be expressed as a function of the parameters of the hierarchical factor analysis model which allows for a general factor that is common to all of the items of a measure in addition to group factors that are common to some but not all of the items of a measure. Alpha may be seen to be quite complexly determined from this perspective. That is, alpha is sensitive not only to general factor saturation in a scale but also to group factor saturation and even to variance in the scale scores arising from variability in the factor loadings. Coefficient omega_hierarchical has a much more straightforward interpretation as the proportion of observed variance in the scale scores that is due to the general factor common to all of the items comprising the scale.

Suppose that we measure a quantity which is a sum of K components (K -items or *testlets*): $X = Y_1 + Y_2 + \dots + Y_K$. Cronbach's α is defined as

$$\alpha = \frac{K}{K-1} \left(1 - \frac{\sum_{i=1}^K \sigma_{Y_i}^2}{\sigma_X^2} \right)$$

Thus the result obtained on finding out the Cronbach Alfa we found the factor customer (.927) which lies between $\alpha \geq 0.9$ and having Excellent (High-Stakes testing) of internal consistency. Manager Skill and Training (.906) which lies between $\alpha \geq 0.9$ is also having Excellent (High-Stakes testing) of internal consistency. Product (.893) which lays $0.7 \leq \alpha < 0.9$ Good (Low-Stakes testing) of internal consistency. Benefits which lays $0.7 \leq \alpha < 0.9$ Good (Low-Stakes testing) of internal consistency.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.726	.701	22

Cronbach alpha was found to be 0.726, which was well above the acceptable value of 0.70 for demonstrating internal consistency of the established scale (Nunnally, 1988)

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy	.798
Bartlett's Test of Sphericity	
Approx. Chi-Square	662.820
df	410
Sig.	0.000

Kaiser-Meyer-Olkin (KMO>0.6) and Bartlett's test of sphericity ($p < 0.05$) were used to test empirically whether the data were likely to factor well (Bikker and Thompson, 2006; Kaiser, 1974; Kline, 1994). In this study KMO measure was 0.888 indicating that the data was adequate for factor analysis. Also, Bartlett's test of sphericity (sig. = 0.000) indicated the significance of the study, thereby showing the validity and suitability of the responses collected. Therefore, the

statistical test showed that the dimensions of instruments were likely to factor well and the questionnaire was multidimensional.

6.6.2 Factor Analysis

Factor analysis of responses was used for data reduction in order to identify correlations among variables in complex sets of data (Mitchelmore and Rowley, 2013) used to gauge the industrial relations. The data gathered from the main survey were analyzed through principal components factor analysis followed by vari-max rotation. It basically partitions the total variance of all original variables by finding the first linear combination of variables that accounts for the maximum variance.

Communalities

SAMPLING	Initial	Extraction
Q1	1.000	.602
Q2	1.000	.765
Q3	1.000	.852
Q4	1.000	.982
Q5	1.000	.321
Q6	1.000	.356
Q7	1.000	.682
Q8	1.000	.602
Q9	1.000	.851
Q10	1.000	.541
Q11	1.000	.245

Q12	1.000	.841
Q13	1.000	.721
Q14	1.000	.521
Q15	1.000	.265
Q16	1.000	.452
Q17	1.000	.652
Q18	1.000	.958
Q19	1.000	.654
Q20	1.000	.358

The communalities represent the total amount of variance an original variable shares with all other variables included in the analysis. The purpose of viewing communalities is to assess whether the variables meet acceptable levels of explanation. 6 out of 20 variables had communalities less than 0.50 indicating they didn't have sufficient explanation and hence were not considered for further analysis. The information regarding the remaining 14 variables and their relative explanatory powers. From the table, it is possible to assess the importance of each component and extract the number of factors with eigen values greater than 1. The six factors extracted captures 62.781% of the variance of the 16 items, which can be deemed sufficient in terms of explained total variance.

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	7.125	31.853	30.851	6.256	30.568	31.542
2	5.256	23.458	51.523	6.259	23.163	52.632
3	3.458	12.151	63.455	3.458	11.162	63.025
4	9.459	9.125	76.259	3.693	8.363	63.782
5	8.632	6.231	83.854	3.586	9.632	64.215
6	7.235	6.258	86.256	3.569	9.756	64.245

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Next, varimax rotational method was employed to achieve simpler and theoretically more meaningful factor solutions. This orthogonal rotation tries to maximize the variance of each of the factors in such a way that the total amount of variance accounted for is redistributed over the seven extracted factors. Table 5 exhibits the factor loadings of the extracted factors after varimax rotation.

6.6.3 Regression Analysis

Thereafter regression analysis was used to examine the extent to which the extracted six factors saved as factor scores affected the industrial relations within the organization. All the six factors were found to be significant predictors of the criterion variable (Industrial Relations). The R square value (indicated that about 50.6 % variance was accounted for by these four predictor variables which was supported by $F = 11.505$ ($p < .05$). The standard error of estimate ($=0.4337$) clearly indicated the reliable prediction of the model.

Model Summary ^b							
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics		
					R Square Change	F Change	df1
1	.826 ^a	0.602	0.485	0.426	0.605	10.206	6

ANOVA ^a						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	9.623	3	3.165	10.205	.000 ^b
	Residual	7.562	42	0.212		
	Total	17.185	45			

The unstandardized coefficients indicate how much the dependent variable goes up, on average, given that the independent variable goes up by one unit. On examination of the standardized β coefficients, it was found that the direction of the influence for all the predictors was positive. An examination of relative influence on the dependent variables indicated that public support is having maximum influence followed by insufficient demand of green product and services. The t-values were significant at 0.000 levels. Tolerance and VIF values of 1 confirmed the non-existence of multi collinearity in this study. Thus on the basis of the results we could conclude that the predictors extracted were significant indicators of industrial relations. Hence, the analysis results established that hypothesis H1b and H2b was supported.

Coefficients ^a					
Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	4.24	0.061		69.13	0
REGR factor score 1 for analysis 1	0.099	0.062	0.167	1.594	0.118
REGR factor score 2 for analysis 1	0.277	0.062	0.469	4.474	0
REGR factor score 3 for analysis 1	0.005	0.062	0.008	0.073	0.942
REGR factor score 4 for analysis 1	0.263	0.085	0.607	4.853	0
REGR factor score 5 for analysis 1	0.321	0.061	0.527	4.921	.652

REGR factor score 6 for analysis 1	0.356	0.067	0.685	4.963	0
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Chapter-7
Observation.

7.1 Observations

The concept of service quality and the marketing initiatives and its impact on the economic development of the society. From the literature review and my in-hand exploration from the service quality and on the marketing initiatives that has been taken in marketing within hospitals, some research questions have been taken into consideration for further examination. These are given as follow. Why service quality and the marketing initiatives is very necessary for hospitals to leverage consumer satisfaction and awareness? How it operates in private and public hospitals? How service quality and the marketing initiatives is applicable in hospitals and how the banks capable of increasing the level of healthcare standards and changing the consumers perception thus also making an impact on the economic development of the society .How does marketing initiatives increase customer mobilization? This paper also tells us about the meaning, existence, types, scope, benefits, limitations of service quality and the marketing initiatives and also includes suggestions to improve service quality and the marketing initiatives in hospitals.

This survey was conducted at Rourkela where this was based on the survey conducted both in public and private hospitals which construed almost all the important hospitals in the city. The data collection was done from patients, friends, relatives who accompanied with the patients, doctors, hospital staff. Factor analysis has been used to examine the hypothesis and the findings of the survey by using IBM SPSS 2013. All the data were represented a 5 point Likert scale. The result of the findings was, service quality and the marketing initiatives is making a considerable comprehensive impact on the society but at some times it generates situations that offer value not only to both to the people residing in that society but also to their loyal customers. This situation clearly defines about the mutation in the level of service quality delivery and the marketing initiatives that is taken by hospitals whether it is through the digital media or non – digital media which supports in informing customers thus also helps in mobilization of customers who are being deprived of availing the quality of service thus offered in the hospitals.

7.2 Recommendations

We analyzed the market of healthcare in accordance with that of the presence of private and public hospitals present in Rourkela. Overall we found that related loyalty levels differed little between competing brands. Indeed the largest difference was for a brand that under-performed compared to its competitors in healthcare sector, and it is reasonable to attribute this to a historical positioning as a road service provider rather than a generalist service provider. Our results indicate that regardless of the investments made into new technologies that are creating benchmark in health care sector and with the use of CRM in tracking customer in order to efficiently design the marketing plan in educating customers, no brands seem to markedly out-perform their direct competitors in terms of loyalty when comparing loyalty for the major products in each market. This indicates that setting ambitious objectives to engender more loyalty (for these major products) in the customer base as a basis for growth may not be realistic – there is an absence of evidence that this can actually be accomplished. Some providers may believe that a way of gaining an advantage over competitors in terms of loyalty metrics is to offer more products/services. However, when the number of products that are offered is controlled for (as we have done in this research), there is very little variation in loyalty metrics between the brands. Given that such massive efforts on marketing initiatives in order to increase category loyalty, more research in this area is needed. There are potentially two streams of future research that could be fruitful. Firstly, do these results hold in other categories, or similar categories in other countries? Secondly, why does brand performance in terms of customer loyalty does not vary very much between competing hospitals? Investigation of consumer purchase behavior may help reveal the answer to this question. We know that healthcare is a market in which there are initial costs that is being bearded by patient in order to know about brands offerings similar service provided by the brand. These are a form of switching cost, and so perhaps once a relationship is established, when consumers have a need for a new product they tend to buy from their existing brand. Meanwhile our results suggest that the hospital management team and the marketing personal should take a very cautious conservative approach to setting targets, particularly when benchmarking against competitors.

Chapter – 8

Conclusion.

8.1 Conclusion

This paper provides a new way of rethinking hospital model of public and private hospitals in informing and uplifting the economy through various dimensions by using quantitative research on intangibles. Based on interviews with hospital staff and marketing managers/ officers, a grounded theory of hospital intangibles is generated, revealing how intangibles and tangible/financial resources interact in the hospitals value creation process and actively respond to environmental changes. It suggests that existing hospital business model should be further developed in a conceptually richer world of intangibles, knowledge and information.

This research paper also clearly suggests a managerial direction focusing on “trust” and “satisfaction” as key factors if practitioners aim to achieve success in customers’ buying intention in healthcare services under the environment of collectivistic culture. “Satisfaction” as key factors if practitioners aim to achieve success in customers’ buying intention in healthcare services under the environment of collectivistic culture. This challenges the predisposition of public and private hospitals spending their energies and resources to compete in pricing, advertising their brands, and in improving or maintaining their reputation act as crucial factors to initiate their first entry into the local market, but in terms of expanding their relationship through stimulating customers’ to buy, they must employ different marketing strategies to either strengthen customers’ “trust” or to revamp existing customers’ “satisfaction” towards their hospital. This paper shows how issues of knowledge and capabilities in hospitals and patients can be related to conventional theoretical ideas in banking, such as intermediation, information problems and risk management. Moreover, the grounded theory generated here provides a means to improve intangible measurement and disclosure, which provides an opportunity for academic researchers to further investigate the role of intangibles in the value creation process using quantitative techniques.

Furthermore, this paper argues that social systems theory and concepts of “performativity” are relevant to understanding the wider context. The creation of common and public knowledge about the hospital business model, and the creation of new bank theory closely matched to this phenomenon may be one of the means to bring together different social systems and their shared

and differing social logics and understandings of hospitals and markets in creating an amicable economic growth in a society.

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Annexure.

Questionnaire.

Name _____

Age _____

Gender _____

Location _____

Income _____

1. What do you look for while searching for the Hospital?

Accessibility Affordability Comfort Infrastructure Doctors

2. Which hospital do you think is the best in Rourkela?

3. Which Hospital do you visit frequently?

4. How do u select a hospital service?

Word of mouth Advertisements Previous Experience Cost benefit Family Doctors

5. How many times have you visited hospitals Rourkela?

0-1 1-5 5-10 10-15 More than 15

6. Do you feel the health screening camps of hospitals in Rourkela are helpful?

Strongly Disagree Disagree Neutral Strongly Agree Agree

7. Do u like the services of hospitals inRourkela?

Strongly Disagree Disagree Neutral Strongly Agree Agree

8. Where did you first know about hospitals inRourkela?

Newspaper Insertions Magazine Doctor Health camp Event

9. When did you last seen hospitals inRourkela Advertisement?

Never Few Weeks Back Few Days Back Frequently Everyday

10. Do you feel the communication material of hospitals inRourkela gives all required information?

Strongly Disagree Disagree Neutral Strongly Agree Agree

11. Are you aware about our all the services provided in hospitals inRourkela?

Strongly Disagree Disagree Neutral Strongly Agree Agree

12. Have you attended any health camps conducted by hospitals inRourkela?

Yes No

13. Do you avail any privileges of the hospitals inRourkela?

Strongly Disagree Disagree Neutral Strongly Agree Agree

14. The overall interaction with the services offered in the hospitals in Rourkela is better than other hospitals.

Strongly Disagree Disagree Neutral Strongly Agree Agree

15. Will you encourage Friends and relative to go to hospitals in Rourkela?

Strongly Disagree Disagree Neutral Strongly Agree Agree

16. Will you consider the same hospital as first choice for the medical services in the future?

Strongly Disagree Disagree Neutral Strongly Agree Agree

17. Do any of your relatives work in any of the hospitals in Rourkela?

Strongly Disagree Disagree Neutral Strongly Agree Agree

18. Is there a wide difference in the cost of the different hospitals in this area?

Strongly Disagree Disagree Neutral Strongly Agree Agree

19. Are the diagnosis that is done is very well organized.

Strongly Disagree Disagree Neutral Strongly Agree Agree

20. Employees are benefited by the service offered in the hospital?

Strongly Disagree Disagree Neutral Strongly Agree Agree

Remarks

Signature.