PERCEPTION OF SERVICE QUALITY OF HEALTH CARE FACILITY IN RURAL AREA OF DELHI

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ABSTRACT
In today’s highly competitive environment, health care services play an important role in individual life. Health care centers realize the importance of service quality as a measure to improve their competitive position. This study has measured perception of the service quality as provided by Delhi Government Dispensaries in rural area of Delhi. The perception on service quality factors in health care has a significant and positive impact on the patients’ perception on the overall performance of the health care centers. The well-designed questionnaire was used as research tool for understanding service quality delivery in Delhi Government Dispensaries. Primary data as collected from 200 users of Delhi Government Dispensaries’. ANOVA and frequency analysis was used to analyses the responses. ANOVA indicate that there is significant variance in patients perception based on the demographic factors such as gender, age, education, profession and annual income of the patients. The frequency analysis brought that patients are satisfied with the availability of doctors and other staff, the behavior of doctors & nursing staff, and the medical care they received. OPD are generally clean and tidy, prescribed medicine is generally available which another positive aspect is. However they found it hard to get appointment in OPD as their use to be long waiting line in OPD it is not easy to get medical care in emergency.

KEY WORD: Service quality, health care services, user perception, rural Delhi.
INTRODUCTION

India has a large public health care system. Primary health care is provided through a network of sub-centers, primary health care centers, community health centers and district hospitals. In rural areas, most primary health care is provided either by sub-centers or primary health care centers; whereas in urban areas it is provided via health posts and family welfare centers. For the provision of health centers, the Indian government has set the following targets:

- One sub-center with one trained female and one trained male health worker per 5,000 persons in the plains and per 3,000 persons in hilly and tribal areas.
- One Primary Health Center (PHC) staffed by a medical officer and other paramedical staff per 30,000 persons in the plains and 20,000 persons in hilly, tribal and backward areas. Each PHC supervise six sub-centers.
- One community health center (CHC) or upgraded PHC with 30 beds and other basic facilities per 80,000-120,000 persons. The CHC is to operate as a referral center for up to four PHCs. (Dalal 2005)

Primary Health Centre (PHC) is the first contact point between village community and the medical officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained by the State governments under the Minimum Needs Program (MNP)/Basic Minimum Services (BMS) Program.

In Delhi both public and private sector agencies provide health care facilities. In public sector the major health care service providers are Department of Health and Family welfare and three local bodies, viz., Municipal Corporation, New Delhi Municipal Council and Delhi Cantonment Board. Delhi Government Dispensaries (DHDs) comprise the second tier in rural healthcare structure which provide integrated curative and preventive healthcare to the rural population with emphasis on preventive and promotive aspects. (Promotive activities include promotion of better health and hygiene practices, tetanus inoculation of pregnant women, intake of IFA tablets and institutional deliveries.) DHDs are established and maintained by State Governments under the Minimum Needs Programme (MNP)/Basic Minimum Services Programme (BMS). A medical officer is in charge of the DHD supported by fourteen paramedical and other staff. It acts as a referral unit for six sub-centres. It has four to six beds for inpatients. The activities of DHD involve curative, preventive, and Family Welfare Services.

India as a nation has been growing economically at a rapid pace particularly after the advent of New Economic Policy of 1991. However, this rapid economic development has not been accompanied by
social development particularly health sector development. Health sector has been accorded very low priority in terms of allocation of resources. Public expenditure on health is less than 1 per cent of GDP in India. It has further witnessed decline during the post economic liberalization period. The meager resource allocation to health sector has adversely affected both access and quality of health services. The unequal access to health services is reported across strata, gender and location (i.e. urban and rural areas). With a view to improve access and quality of health services, government should enhance public spending on health sector in the vicinity of 3 per cent of GDP. Generally rural public health facilities across the country are having a difficult time attracting, retaining, and ensuring regular presence of highly trained medical professionals. The higher the level of training required for the position, the greater is this need gap.

The present study is aimed at finding the perception of service quality of rural health facilities as provided by the Delhi Government Dispensaries spread across the rural villages in Delhi.

LITERATURE REVIEW

Service quality in health care is defined as the totality of features and characteristics of a product or service that bear on its ability to satisfy stated or implied needs (Korwar, 1997). Health care service quality is giving patients what they want (patient quality) and what they need (professional quality), and doing so using fewest resources, without error, delays and waste, and within higher level regulations (Overtreit, 1992).

Considering an issue of quality focus in Healthcare, there is no one common understanding concerning who plays the main role in identifying its quality. It could be argued that the main focus should be made on patients as customers because they could leave “the consumption loop” while their presence in it is essential for a healthcare organization functioning (Owusu-Frimpong, 2010, p. 204). Also within the study of O’Connor et al. (1994, p. 32) patients’ perspectives were defined as “a meaningful indicator of health services quality” and could depict the most vital perspective. Another notion on a quality focus in Healthcare was introduced by Sower et al. (2001, p. 50). They expressed that quality characteristics should be recognized mutually by patients and health service providers as both of them have “valuable insight” on features that create quality in hospitals. So, making comparison with customers-oriented focus in Service Quality, it is visible that Healthcare service quality focus is distinctive to some extent as some authors incorporate not only customers’ perception of quality but service providers’ perception as well.

Mutual approach toward service quality will cause necessity to deal with a gap that is discrepancy between customers’ and service providers’ perception of service quality (Miranda et al., 2010, p. 2138). It should be remembered that healthcare services as well as general services are existing for
customers’ satisfaction and even if healthcare service providers have their own essential opinion on healthcare service quality, they should always keep in mind that the core place is allocated to customers and direct their strengthens to deliver their services in line with their expectations and needs (Scotti et al., 2007, p. 111)

Doran and Smith (2004, pp. 379-381) presented two categories outcome and tangible that could be referred to technical category because outcome was presented as the things which patients want to receive from healthcare service and tangible aspect was depicted as physical facilities, equipment, and appearance of various staff. Also they stressed empathy as caring and individualized attention to patients, assurance as staff ability to inspire trust, responsiveness as willingness to help patients and deliver responsive services, and reliability as consistency and dependability of healthcare services.

Service quality in health care is supplemented by two additional concerns, namely physician and staff. Representatives of the latter are other medical staff rather than physicians such as nurses, receptionist and others (Choi et al., 2005). Existence of two distinctive representatives of health service providers is a specific characteristic of the healthcare industry.

Miranda et al. (2010,) suggested adjusting SERVQUAL to the healthcare industry by recognizing two types of employees, namely health staff and non-health staff. The outcome of their research was HEALTHQUAL model that involved four factors. These factors are:

1. **Health staff**: They are medical professionals involved in communication, attention, understanding and solving patients’ problems.

2. **Non-health staff**: They are non-medical professionals involved in professionalism, kindness and politeness, attention to patients’ problems, interest in solving patients’ problems.

3. **Efficiency measures**: Level of bureaucracy, waiting times in the health centre before entering the consulting room, speed of complementary tests, complaints resolution, time to focus on each patient, the health centre’s timetable.

4. **Facilities**: Availability, operation ability, cleanliness of facilities & equipment at the centre, and location of the centre.

Sofaer and Firminger (2005) found seven dimensions of health care. These dimensions are:

1. **Patient-Centered Care**: It relates to individualized care, patients involvement in their care and decision-making about their care, doctors, nurses, and staff having personalized knowledge of patients etc.

2. **Access**: It stands for availability and accessibility of doctors, nurses, and staff, affordable care, convenient places and times for visits; access to urgent care, assistance in navigating the health system etc.
3. Communication and Information: Providing the timely information and communication of different facilities and their usability to the patients


5. Technical Quality: Availability of required medical equipment related to testing and diagnostic facilities, a variety of clinical services available, use of up-to-date technology such as computers, and the visibility of the care provider in the community.

6. Efficiency of Care/Organization: It is described as accurate billing, efficient referral processes, short waiting times for appointments and at ancillary settings etc.

7. Structure and Facilities: It includes availability of parking, safety and security in and around the facility, cleanliness and comfort, quality of food provided, a quiet and pleasant environment.

Lehtinen and Jukka (1985) present a holistic view to measure, monitor, and operational customer perceptions of service quality in health care organization. Increase in urbanization and standard of living of the people, the awareness on health care services also increases. The consumer’s expectation on the quality in health care services is increasing at a faster rate. Service quality has been shown to be an important element in the consumer’s choice of hospitals (Lynch and Schuler, 1990). John (1989) opined that there are three dimensions of health care service quality: these are the caring dimension, the access dimension, and the physical environment.

Sharma and Chahal (1995) identified the need of evaluating the service quality of health care service. Bowers et al., (1994) studied the five common attributes of service quality and their applicability in health care. They found that caring and communication were significant dimensions and three generic SERVQUAL dimensions namely empathy, responsiveness and reliability were found to be related significantly to patient satisfaction. The strategy for patient satisfaction in health care service requires effective marketing plans, policies, and practices to genuinely meet the needs of different strata of population. This concept drew the attention of the service providers in the early 70s and the health care providers in advanced countries became conscious of satisfying patients (Cooper et al. 1979; Kotler and Zaltman, 1970; Woodside et al. 1989 and Hexner et al. 1985). The major reasons that have necessitated a shift towards marketing approach are intense competition, more patient awareness, increased purchasing power of patients, and availability of specialists (Yadav, 1993). The progress of service unit depends on the patient satisfaction and service quality in all developing and developed countries (Cronin and Taylor, 1992).

Takeuchi and Quelch (1983) assessed the service quality of health care services by six dimensions: a) reliability, b) service quality, c) prestige, d) durability e) punctuality and f) ease of use. Walters (2001)
judged the quality of service in health care organization by reliability, availability, credibility, security, competence of staffs, understanding of customer needs, responsiveness to customers, courtesy of staffs, comfort of surroundings, communication between participants and associated goods provided with the service. Griffith and Alexander (2002) compared the service quality rendered by private and public hospitals. Rohini and Mahadevappa (2006) stratified the hospitals on the basis of specialty and non-specialty; Government-Private; and missionary, ISO-9000 certified and ISO-9000 non-certified. Abu Naser et al., (2006) analyzed the customer expectations and perceptions towards health services especially in Diagnosis services.

According to Price water house Coopers (2007) the health care industry is one of India’s largest sectors in the service industry in terms of revenue and employment and this is growing rapidly. In India, the service quality of health care is miserable and in general, the health outcome is far from satisfactory (Bajpai and Goyel, 2004). Therefore, government of India has adopted a policy of health care reform having two basic objectives to achieve health securities for all and to provide quality health facilities for all within every district in India (John, 2010). In the health care sector, customer satisfaction is also an important issue as in other service sectors (Shabir et al. 2010). A health care organization can achieve patient satisfaction by providing quality services; keeping in view patients’ expectation and continuous improvement in the health care service (Zineldin, 2006).

Mutawa et. al. (2006), have mentioned that service or product itself is one of the principal factors of customer satisfaction. It can be defined as a system that customer goes through to receive the value for money. Newman et. al. (2001) opined that customer service is a prerequisite for customer satisfaction. The value of service consists of eight dimensions viz. reliability, assurance, access, communication, responsiveness, courtesy, empathy, and tangibles (Brown, 1997; Caruana and Pitt, 1997; Cooke, 1998; Homburg and Garbe, 1999; Clemes et al., 2001; Sower et al., 2001; Yang et al., 2003).

**OBJECTIVES AND HYPOTHESES**

This study seeks to find out the effectiveness of service quality of health care services in rural Delhi in Delhi.

In pursuance of the above objectives, the following hypotheses were formulated for testing:

- **H01** There is no significant difference is perceived by patients in the service quality of health care facilities on the basis of gender of the patients.

- **H02** There is no significant difference is perceived by patients in the service quality of health care facilities on the basis of age of the patients.
- $H_03$: There is no significant difference is perceived by patients in the service quality of health care facilities on the basis of education of the patients.

- $H_04$: There is no significant difference is perceived by patients in the service quality of health care facilities on the basis of profession of the patients.

- $H_05$: There is no significant difference is perceived by patients in the service quality of health care facilities on the basis of annual income of the patients.

**RESEARCH METHODOLOGY**

**DATA COLLECTION METHOD**

**PRIMARY DATA**

The main instrument used for primary data collection in this research was the questionnaire; the responses have been collected by means of face-to-face interviews by authors.

**QUESTIONNAIRE DEVELOPMENT**

Questionnaire development is the critical part of primary data collection method. Questionnaire was designed to collect all relevant information regarding the project. The questionnaire was designed to study perception of user of rural health care system. Likert five point scales ranging from strongly agree to strongly disagree was used for obtaining responses.

**SAMPLING PLAN**

(i) **Sampling Unit**: This call for defining the target population to be surveyed. In this research the sampling unit was the patients visiting Delhi Government Dispensaries located in rural area of Delhi. Random sampling method was adopted to select the customers.

(ii) **Sample Size**: In this survey the sample size decided was 200. This is fairly large enough to represent the population.

(iii) **Sampling procedure**: To obtain a representative sample, a probability sample of population was drawn. For studying perception on healthcare services, samples were selected randomly from patients visiting Delhi Government Dispensaries rural area of Delhi. In simple random sampling every member of the population has an equal chance of being selected in sample.

(iv) **Contact Methods**: In this research the intercept interview method was adopted because it is not possible to take appointment from a large number of respondents. Respondents were told about the purpose of this research and were helped in understanding any particular question in case there was any need. Sufficient time was given to respondents to go through the questionnaire before recording their responses. The questionnaire was administered to 200 respondents at different locations in Delhi, Authors has taken due care so as not to
influence the respondent while recording the responses. Also the author has ensured that no personal bias or distortion take place while recording the responses.

**RESEARCH AND STATISTICAL TOOLS EMPLOYED**

The research and statistical tools employed in this study are ANOVA and frequency analysis. SPSS 16 was used to perform statistical analysis. The reliability of the data was carried out by using Cronbach’s Alpha Value. Frequency analysis on the main factor under study, indicate overall satisfaction levels of respondents with health facility. ANOVA was carried out to find the variance in the responses and to test the hypothesis.

**DATA ANALYSIS AND INTERPRETATION**

The analysis of this data was divided into following section:

(i) Demographic profile of Respondents : Table 1
(ii) Reliability and Validity : Table 2
(iii) ANOVA : Table 3
(iv) Frequency Analysis : Tables 4

**DEMOGRAPHIC PROFILE OF RESPONDENTS**

The respondent profile as displayed in table 1 replicate typical rural population of Delhi. Most of the respondents are employed either in private sector (31%) or government sector (29%), were either graduate (22%) or 10+2 (52%) in the age group of 41-50 years (42%) or above 50 years (38%). Their annual income is less than Rs 300000 (71%) and who cannot afford the private health care facilities and are dependent on the government health care facilities. The profile of respondents is similar to the actual user of these health facilities.

**Table 1: Demographic profile of Respondents**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Characteristics</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>124</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>76</td>
<td>38</td>
</tr>
<tr>
<td>Age group</td>
<td>20-30 yrs</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>31-40 yrs</td>
<td>22</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>41-50 yrs</td>
<td>84</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>51 yrs &amp; above</td>
<td>76</td>
<td>38</td>
</tr>
<tr>
<td>Education</td>
<td>Post-Graduation</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Graduation</td>
<td>44</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>10+2</td>
<td>104</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Matriculation or below</td>
<td>36</td>
<td>18</td>
</tr>
</tbody>
</table>
RELIABILITY AND VALIDITY
Table 2 shows the result of reliability analysis- Cronbach’s Alpha Value. This test measured the consistency between the survey scales. The Cronbach’s Alpha score of 1.0 indicate 100 percent reliability. Cronbach’s Alpha scores were all greater than the Nunnaly’s (1978) generally accepted score of 0.7. In this case, the score was 0.769 for the service quality provided by the government rural health services.

Table 2: Reliability Analysis-Scale (ALPHA)

<table>
<thead>
<tr>
<th>Practices /Services</th>
<th>Number of Cases</th>
<th>Number of Items</th>
<th>Alpha Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Quality</td>
<td>200</td>
<td>20</td>
<td>0.769</td>
</tr>
</tbody>
</table>

HYPOTHESIS TESTING: ANOVA COMPUTATION
In order to test the hypothesis ANOVA was carried out. The results are given below. Table 3 gives the result of ANOVA computation on the basis of gender, age education, profession and annual income of the respondents.
### Table 3: Computation of ANOVA

<table>
<thead>
<tr>
<th>Characteristics/ Attributes</th>
<th>Gender F</th>
<th>Gender Sig.</th>
<th>Age F</th>
<th>Age Sig.</th>
<th>Education F</th>
<th>Education Sig.</th>
<th>Profession F</th>
<th>Profession Sig.</th>
<th>Annual Income F</th>
<th>Annual Income Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance of health facility from home</td>
<td>.000</td>
<td>.000</td>
<td>.91.467</td>
<td>.000</td>
<td>.90.536</td>
<td>.000</td>
<td>.18.107</td>
<td>.000</td>
<td>.7.597</td>
<td>.000</td>
</tr>
<tr>
<td>Easy to get medical care in Emergency</td>
<td>34.472</td>
<td>.000</td>
<td>.86.987</td>
<td>.000</td>
<td>.216.450</td>
<td>.000</td>
<td>.93.321</td>
<td>.000</td>
<td>.23.520</td>
<td>.000</td>
</tr>
<tr>
<td>Hard to get Appointment in OPD</td>
<td>73.543</td>
<td>.000</td>
<td>.21.407</td>
<td>.000</td>
<td>.17.094</td>
<td>.000</td>
<td>.83.511</td>
<td>.000</td>
<td>.60.107</td>
<td>.000</td>
</tr>
<tr>
<td>Long waiting line in OPD</td>
<td>11.904</td>
<td>.000</td>
<td>.7.976</td>
<td>.000</td>
<td>.13.929</td>
<td>.000</td>
<td>.134.380</td>
<td>.000</td>
<td>.49.867</td>
<td>.000</td>
</tr>
<tr>
<td>Doctor listen carefully</td>
<td>3.960</td>
<td>.048</td>
<td>.86.987</td>
<td>.000</td>
<td>.67.566</td>
<td>.000</td>
<td>.29.250</td>
<td>.000</td>
<td>.39.200</td>
<td>.000</td>
</tr>
<tr>
<td>Doctor treat patient in friendly manner</td>
<td>13.382</td>
<td>.000</td>
<td>.24.967</td>
<td>.000</td>
<td>.22.713</td>
<td>.000</td>
<td>.69.164</td>
<td>.000</td>
<td>.52.267</td>
<td>.000</td>
</tr>
<tr>
<td>Doctor are available as per timings</td>
<td>1.029</td>
<td>.312</td>
<td>.14.933</td>
<td>.000</td>
<td>.61.579</td>
<td>.000</td>
<td>.48.000</td>
<td>.000</td>
<td>.55.067</td>
<td>.000</td>
</tr>
<tr>
<td>Same doctor on every visit</td>
<td>10.800</td>
<td>.001</td>
<td>.14.442</td>
<td>.000</td>
<td>.34.412</td>
<td>.000</td>
<td>.7.800</td>
<td>.000</td>
<td>.2.033</td>
<td>.111</td>
</tr>
<tr>
<td>Availability of prescribed medicine</td>
<td>142.560</td>
<td>.000</td>
<td>.4.900</td>
<td>.003</td>
<td>.3.656</td>
<td>.007</td>
<td>149.842</td>
<td>.000</td>
<td>112.098</td>
<td>.000</td>
</tr>
<tr>
<td>Doctors intentionally prescribe medicines from private medical stores</td>
<td>117.984</td>
<td>.000</td>
<td>.12.464</td>
<td>.000</td>
<td>.14.138</td>
<td>.000</td>
<td>.56.062</td>
<td>.000</td>
<td>.25.780</td>
<td>.000</td>
</tr>
<tr>
<td>No. of doctors and other staff are adequate</td>
<td>3.960</td>
<td>.048</td>
<td>.29.867</td>
<td>.000</td>
<td>.26.591</td>
<td>.000</td>
<td>.50.700</td>
<td>.000</td>
<td>.57.223</td>
<td>.000</td>
</tr>
<tr>
<td>Behavior of nursing staff is good</td>
<td>58.195</td>
<td>.000</td>
<td>.15.680</td>
<td>.000</td>
<td>.19.943</td>
<td>.000</td>
<td>.7.922</td>
<td>.000</td>
<td>.16.361</td>
<td>.000</td>
</tr>
<tr>
<td>OPD are clean and tidy.</td>
<td>18.635</td>
<td>.000</td>
<td>.53.223</td>
<td>.000</td>
<td>.52.000</td>
<td>.000</td>
<td>.4.588</td>
<td>.001</td>
<td>14.352</td>
<td>.000</td>
</tr>
<tr>
<td>I visit govt. dispensaries because there is no other option</td>
<td>9.138</td>
<td>.003</td>
<td>.53.138</td>
<td>.000</td>
<td>.89.375</td>
<td>.000</td>
<td>.22.286</td>
<td>.000</td>
<td>.2.150</td>
<td>.095</td>
</tr>
<tr>
<td>Satisfied with the received medical care</td>
<td>5.858</td>
<td>.016</td>
<td>.2.333</td>
<td>.075</td>
<td>.13.805</td>
<td>.000</td>
<td>14.552</td>
<td>.000</td>
<td>5.275</td>
<td>.002</td>
</tr>
</tbody>
</table>

The result of ANOVA computation shows that significant differences is perceived by male and female respondents for majority service quality attributes of rural health facilities. Hence we reject the $H_{01}$. This indicates that both male and female customer perceive rural health facilities in different way. Similarly we find that ANOVA computation shows that significant differences is perceived by the patients on the basis of age, education, profession and annual income. This leads to rejection of $H_{02}$, $H_{03}$, $H_{04}$, and $H_{05}$. [42]
FREQUENCY ANALYSIS OF PATIENT’S PERCEPTION

In order to find out patients perception and the overall satisfaction, frequency analysis has been carried. The result is presented in the table 4. Strongly agree and agree responses are the supporting responses of the statement related to a particular attribute of the rural health care facilities. Disagree and strongly agree responses are those which do not support the statement related to a particular attribute. Neutral responses neither support nor oppose the attribute.

Table 4: Frequency Analysis of patient’s perception of Health care service quality

<table>
<thead>
<tr>
<th>Characteristics/ Attributes</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Moderate</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance of health facility from home is walking distance</td>
<td>28</td>
<td>51</td>
<td>00</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Easy to get medical care in Emergency</td>
<td>09</td>
<td>17</td>
<td>23</td>
<td>39</td>
<td>12</td>
</tr>
<tr>
<td>Hard to get Appointment in OPD</td>
<td>19</td>
<td>42</td>
<td>21</td>
<td>15</td>
<td>03</td>
</tr>
<tr>
<td>Long waiting line in OPD</td>
<td>18</td>
<td>41</td>
<td>19</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Doctor listen carefully</td>
<td>09</td>
<td>42</td>
<td>23</td>
<td>14</td>
<td>07</td>
</tr>
<tr>
<td>Doctor treat patient in friendly manner</td>
<td>10</td>
<td>41</td>
<td>27</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Doctor are available as per timings</td>
<td>12</td>
<td>32</td>
<td>29</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Same doctor on every visit</td>
<td>12</td>
<td>50</td>
<td>21</td>
<td>13</td>
<td>04</td>
</tr>
<tr>
<td>Availability of prescribed medicine</td>
<td>11</td>
<td>32</td>
<td>28</td>
<td>20</td>
<td>09</td>
</tr>
<tr>
<td>Doctors intentionally prescribe medicines from private medical stores</td>
<td>16</td>
<td>39</td>
<td>21</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>No. of doctors and other staff are adequate</td>
<td>14</td>
<td>36</td>
<td>12</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>Behavior of nursing staff is good</td>
<td>12</td>
<td>42</td>
<td>22</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>OPD are clean and tidy.</td>
<td>09</td>
<td>51</td>
<td>18</td>
<td>14</td>
<td>08</td>
</tr>
<tr>
<td>I visit govt. dispensaries because there is no other option</td>
<td>10</td>
<td>40</td>
<td>23</td>
<td>19</td>
<td>08</td>
</tr>
<tr>
<td>Satisfied with the received medical care</td>
<td>15</td>
<td>44</td>
<td>21</td>
<td>11</td>
<td>09</td>
</tr>
</tbody>
</table>

The analysis find that majority of respondents agreed that health facility is walking distance from home where as whereas 51% said that it is not easy to get medical care in emergency. 61% find it hard to get Appointment in OPD and 59% said there is long waiting line in OPD. However majority of respondent said that Doctor listen carefully, treat patient in friendly manner, Doctor are available as per timings and they find the same doctor on every visit. It was found that prescribed medicines are available in dispensaries (43%) but Doctors intentionally prescribe medicines from private medical stores (55%). The positive aspects found that there are adequate number of doctors and other staff, the behavior of nursing staff is good, OPD are clean and tidy and patients are satisfied with the
medical care they received. Majority of patients (59%) visit government dispensaries because there is no other option for them and they cannot afford private medical facility either because of their income or accessibility.

**CONCLUSION**

Most of the rural areas are concentrated in North and South West Delhi where there is no big private or government hospital and Delhi Government Dispensaries play important role in providing the health services in rural area of capital. Hence they become the integral part of the life of this area. The present paper made an attempt to find the service quality perception of the patients visiting this health facility. ANOVA indicate that there is significant variance in patients perception based on the demographic factors such as gender, age, education, profession and annual income of the patients. The frequency analysis brought that patients are satisfied with the availability of doctors and other staff, the behavior of doctors & nursing staff, and the medical care they received. OPD are generally clean and tidy, prescribed medicine is generally available which another positive aspect is. However they found it hard to get appointment in OPD as their use to be long waiting line in OPD it is not easy to get medical care in emergency. These issues can be resolved by increasing the number of medical staff at these facilities.
REFERENCES


