CHAPTER-1
INTRODUCTION

1. Background
Modern Hospitals need to address improving the patient experience not as a short term fix but as a long term strategic goal that leads to continued growth. “Improving patient satisfaction is key to future survival,” says Irwin Press (Tequia Burt, 2006). Improving the patient experience in healthcare organisations can lead to higher quality care, more satisfied staff, fewer preventable medical mistakes, fewer malpractice, law suits and an improved financial bottom line. It also can lead to a significant competitive growth strategy (Frank J. Sardone and Sue Reinoehl, 2006). Word of mouth publicity about how a hospital maintains its relationships with patients can either increase visits or send potential patients to another hospital. The manner and environment in which care is delivered, how well a doctor explains the treatment, how a nurse administers medication, the level of noise, all contribute to a patients care experience. Thus, to promote change in the performance of health care personnel strategies that focus on the environment in which the workers practice must be considered. The main challenge is to continue to maintain or improve the quality of the care provided and maintain, or even expand, the comprehensiveness of health service coverage, while simultaneously introducing changes in care delivery or service mix (Michael Pfeil 2003) necessitated by reduced budgets (Janne D, unham-Taylor and Joseph Z. Pinczuk, 2004, John R Welch and Brain H. Kleiner, 1995).

Governments at local, regional and national levels are attempting to obtain greater value for the money they spend on health care. Faced with growing expectations of quality, they are being asked to be more accountable for the results of their health care expenditures. Thus, they also have an important role to play in ensuring and improving the quality of health services provided in both the public and private sectors. On the other hand, healthcare providers have to take more and more responsibilities which demands high skills, positive attitudes, greater knowledge and exemplary behaviour as a part of the process of health services delivery. The way the health care system is structured, including the number and types of health care personnel available, and how they are deployed and distributed, can all
influence the quality of the services delivered. The pace at which change is occurring, the availability of technology needed to deliver quality care, and the expertise and style of health care resource management available may also influence quality (Thomas C Dolan, 2004, Ellen Lanser 2004 Micael N 2004).

Entry-level knowledge, skills and understandings of health care workers are affected by the quality of the basic educational system, the links between the health education and health care sectors and the extent to which the educational system promotes continuing learning skills and models multi-disciplinary cooperation. The ability of the existing workforce to acquire new skills may also be limited by the support available through the educational system (e.g. library, courses, distance learning opportunities and information systems) (J A Royle et al June 2000). The organisational focus should be on creating competent professionals who involve patient safety and care. Also, the organisational effort spent on improving climate and culture will facilitate the employees to participate with greater degree of autonomy, having self confidence, ability to take own decision with regard to job, work with positive attitude (Roseanne C. Moody and Daniel J.Pesut, 2006), protection from the workplace violence, show strong commitment on work, develop better relationships among the work groups, work with free of stress, learn leadership skills and attain a higher level of job satisfaction.

In the process of healthcare delivery nurses’ role is considered a key factor. In all countries nurses provide the majority of health services – up to 80 per cent in some cases (Graham S Lowe, 2006). Secondly, it is pointed out that nursing as a task consumes and controls too large a proportion of the hospital resources, to be left to develop in isolation or as an afterthought to clinical reorganization.

As nurses are the key healthcare providers and share major responsibilities of patient care, they need to work in an environment which will lead to better performance (Koichiro Otani and Richard S Kurz 2004, Donna K McNease – Smith, 2001, Gail Sott, 2001). This research study aims to study the conditions in which nurses function and what more can be done to make the nursing job more effective in public sector hospitals in Mumbai.
Indian Health Scenario

India constitutes 17 per cent of the world’s population which makes it the second most populated country in the world. Since India shifted to structural adjustment policies and liberalization the Indian economy has grown at a fast rate, though concerns on equity and poverty persist. The country has recently become one of the world’s fastest growing economies with an average growth rate of over eight per cent in last few years. At the same time, new public health challenges have emerged in the form of changing demographics and environmental conditions; emerging infectious diseases and anti-microbial resistance, behavioural issues influencing health and the increasing focus on non-communicable diseases. However, the country has made significant strides on many health fronts and these must be rightfully acknowledged such as increased life expectancy, reduction in maternal and infant mortality and eradication of smallpox.

Public Health Sector

The public health sector consists of the central government, state government, municipal & local level bodies. The Ministry of Health and Family Welfare is head of the central government health structure. The same administrative structure is more or less repeated at the level of each state government. At the district level there is a District Medical Superintendent in charge of a district hospital / hospital functions and a Chief Medical Officer / District Health officer in charge of rural non hospital functions. With regard to the municipalities in cities and small towns they have their own hierarchy for their health programs. There are diverse types of health institutions in the public health sector. Services are provided mainly through its various teaching, non-teaching, district, civil, cottage, rural, peripheral hospitals, and certain specialty hospitals meant for specific illness such as tuberculosis, leprosy, mental and maternity homes.

The large cities depending on their population have a few state run hospitals (including teaching hospitals). They also have local body run hospitals and dispensaries. In the rural areas of the district, under the primary health care delivery system, there are Community Health Centers (CHC), Primary Health Centers
(PHCs) and Sub Centers (SCs) that provide various health services and outreach services. Each CHC is supposed to cover 100,000 people and provide multi-functional services with 30 inpatient beds. The city hospitals and the civil hospitals are basically curative centers providing outpatient and inpatient services for primary, secondary and tertiary care. In urban areas, big cities and towns have municipal corporations to look after the health needs of its population, and health services are provided through a network of Urban Family Welfare Centers (UFWC) and Health Posts (coverage is approximately 1.5 lakh people) and Post Partum Centres (Academy for Nursing Studies, 2005).

**Present Context of Public Health sector**

Health is a very important concern of state and Central Governments. The Central Government’s intervention to assist the State Governments is needed in the areas of control/eradication of major communicable and non-communicable diseases, broad policy formulation, regulatory aspects with regard to medical education, containment of population growth including child survival and safe motherhood and immunisation programmes. The health system in India is linked to greater participation of both State and Central Governments. However, the state Government is largely responsible for community health. Enhancements in health systems performance have made a tremendous impact on the overall development of the nation.

One of the major functions of health systems is the financing of health care. Financing of health care includes collection of revenue, mobilising or pooling financial resources, and utilised their sources effectively and efficiently (allocation of resources to right interventions). Healthcare system is considered to be fairly financed if the ratio of contribution of each household to its ability to pay is identical for all households, independent of the household’s state of health or use of health systems. Fair financing deals with whether funds are received through progressive collection mechanisms and protection of catastrophic health expenditure directly WHO defines health expenditure as “catastrophic” whenever it is greater than or equal to 40 per cent of the capacity to pay (total household non – subsistence effective Income). Mobilisation funds are continuous activities and the
responsibility of any country. While looking at the various sources of finance schemes from the users, the user fee was not considered as the main sources of income. There are five broad ways of revenue collection for health care financing, namely, general revenue (taxation); social health insurance, voluntary or private health insurance; out-of-pocket payments (User fees), and internal donations. World Bank has brought the user charges into the real scenario (National Health Accounts).

The public health expenditure in India is amongst the lowest in the world as a share of GDP at less than 1 per cent. What is more, as a proportion of the total health expenditure, it accounts for fewer than 20 per cent, making India a member of a small group of nations in extreme distress - like Cambodia and Afghanistan. Private health expenditure accounts for 80 per cent of the total health care costs. Most of the private expenditure is out-of-pocket (nearly 97 per cent), as there is neither health insurance coverage for the bulk of the people, nor a viable risk-pooling mechanism. As a result, the economic consequences of ill health are devastating for most families. Surveys show that a single episode of hospitalisation costs a family about 60 per cent of the annual income, on average. This high average out-of-pocket expenditure applies to all cases of hospitalisation. This is because even in public hospitals, costs are incurred for transport, accommodation and board for the patient and attendants, bribes, and often diagnostic investigations at private facilities and purchase of drugs unavailable in government hospitals. As a result, 40-60 per cent of hospitalised patients borrow heavily at high interest, and up to 30 per cent end up slipping below the poverty line on account of healthcare costs. According to the first systematic analysis carried by National Health Accounts in 2001-2002 the breakup of healthcare expenditure is as follows:
The low expenditure on public sector brings poor health facilities and infrastructure to the population. Further the people find insufficient health care facilities for their healthcare requirement. In the absence of right treatment the people get affected their health further it impact on the individual’s productivity and economic developments because the greater reliance on private delivery of health infrastructure and health services therefore means that overall these will be socially underprovided by private agents, and also deny adequate access to the poor. This in turn has adverse outcomes not only for the affected population but for the society as a whole. It adversely affects current social welfare and labour productivity, and, of course, harms future growth and development prospects. However, the public health system cannot take care of the health care requirements of the population because of its drawbacks at various levels.

**The Overall deterioration of Public Health Services**

In public sector hospitals there are very frequent shortages of drugs, linen and other items which are a major concern. Due to this shortage of consumables and medicines, the patients or their relatives are often angry because they have to pay for services that are supposed to be free. Sometimes even life-saving drugs like adrenaline are often missing in emergency rooms and operating theatres. Further there has been no effort from the hospital authorities to management of stock and distribution of such items to the ward systematically. Some times the nursing staff

![Healthcare Spending in India](chart.png)

Source: National Health Accounts for India, 2001-02
and doctors do the administrative work of stock maintenance at the cost of providing medical care. The list of drugs in stock, displayed in the hospital outpatient department (OPD), is not regularly updated and doctors in the OPD prescribe drugs based on the outdated list. At the dispensary patients are told that the drugs are out of stock; either they must be purchased from outside at their own expense or they must get the prescription changed, which means going back to the crowded OPD. Further, diagnostic equipment such as ultrasound and X-ray machines are routinely out of order, forcing patients to get these investigations done at private centres for a fee. The patient’s relatives are asked to take on substantial responsibility for nursing the patient. They are required to be present almost round-the-clock in the hospital. Yet, there are no bath, rest or food facilities for them. All these issues affect not only the nursing staff but also other categories of staff.

The shortage of personnel – either because of under-staffing or because of rampant absenteeism among the support staff including nursing staff gravely affects the quality of care. Nurses and doctors are compelled to do jobs like crowd management, pushing trolleys, getting drugs and equipment and escorting patients between departments. This affects their interaction with patients. They also feel that such work reduces their status in the eyes of the relatives. It does not help that residents are bullied by ward staff who view them as novices. The stress is compounded by the environment of the outpatient department, where crowds of patients, each pushing case papers to get the doctor's attention, surround doctors and nurses. If a Class IV staff is absent there is no system to manage the stream of patients. The external pressures from the politicians in government hospitals also hampers nurses’ and doctors’ routine jobs.

The most common grievance of patients is the hospital staff's rude behaviour. Very few providers are polite and treat patients with respect. Patients said they themselves were violent only under severe provocation. Other major grievances were delays, being shuttled from department to department and poor communication about the patient's condition. On an average, the patients were more upset about the constant demands to buy drugs and supplies from private
pharmacies. In general, patients and their relatives felt helpless. Another common complaint was that doctors and nurses did not respond to calls from patients.

Nurses' abysmal wages and working conditions have not been affected by the many committees on the subject. Nursing also occupies the lowest rung in the sexual division of labour in the health system. Inadequate professionalisation of nursing in our country has made this profession almost completely subordinate to the doctors' profession, so much so that in many states doctors are appointed as presidents of nursing councils. Studies have shown that these factors promote a negative stereotype of women in nursing, one which has made them vulnerable, added to their job-related stress and made them the target of sexual harassment. However, the problems of nurses are not only those of wages and working conditions. While it is important to win a specific trade union battle, this will not provide a lasting solution. Since their problems are also rooted in the social status of nursing, their insufficient professionalisation and the neglect of their colleagues in the private sector, they will need wider social support to solve these problems.

In brief, the public health sector has wider and major role to play in health care systems. It has lot of challenges particularly care for the poor, and their access to healthcare. Also, it has to ensure equity, efficiency and compensate the areas which are inadequately addressed by private healthcare organisations. The public health system should mobilize the funds and make provisions for appropriate expenditure (heavily criticized by a wide range of experts group in the country). The public hospitals are deficient in managing finance, human resources, equipment and material procurement and utilisation, maintenance systems etc. The public hospitals primarily focus on human resource management because it consumes large resources (David Brookfield 2000). In hospitals various categories of staff work as a team and provide service to the patients. Since the public health sector aims to serve the various segments of average, below average, poor income and the under privileged populations, the researcher has interest on working this areas to address the environmental issues in this work and bridge the knowledge gap. This study attempts make some meaningful contribution to this sector.
Nursing in India

The history of professional nursing education in India began in the 19th century. British military hospitals and Christian missionaries were responsible for initiating public health nursing. In the beginning lady health visitors, rural midwives, and maternity assistants were trained for 30 working days and later Auxiliary Nurse Midwives (ANMs) and nurse midwives were also included. The first school to train midwives with an additional course in midwifery after nursing was started in 1854 in a lying-in hospital at Madras. The Indian Nursing Council (INC) designed the two-year curriculum to prepare ANMs to provide basic nursing care, preventive services, midwifery and child care services in rural areas. The first such school came up in 1951 at St. Mary’s Hospital, Taran-Taran, Punjab. From two schools in 1952 the number of ANM training schools increased to 263 by 1962. Primarily the maternal healthcare was taken care of ANMs. The University Education Commission headed by Dr. S. Radhakrishnan (1949) and the Education Commission headed by Dr. Kothari (1964), both, recommended raising the standard of nursing education by linking it with higher education of academic value at the university level. At the time of the Radhakrishnan Commission only two colleges of nursing were enlisted - one at Delhi, affiliated to the Delhi University, and another at Vellore affiliated to the University of Madras, both giving a B.Sc. degree in Nursing. The Trained Nurses' Association of India, launched in 1905 was instrumental in the establishment of college education. Currently, available nursing courses in India are the eighteen months Multiple Public Health Workers (female) (MPHW(F)) training after Class X, the General Nursing and Midwifery Diploma (GNM), B.Sc. (Nursing), M.Sc. (Nursing), M.Phil. and Ph.D. in Nursing. The Indian Nursing Council approves the State Nursing Councils, provides guidance, enforces standards, and formulates policies for equivalence and reciprocity of educational qualifications across the states in India. A study conducted in six states of the country indicates that Nursing Councils in India are largely headed and controlled directly or indirectly by the administrative in-charge of the medical and health services belonging to the medical profession. Only recently the INC has got a head with a nursing background (Rustomfram, N. 1999).
Nursing in Maharashtra
In Maharashtra Nursing Services were started by Nursing Associations. The Nursing Association was formed by philanthropists and lay persons (particularly Sir Ness Wadia in 1920) at the Government run J.J. group of hospitals in Mumbai. In 1928 Mrs.T K Adranvala was appointed as the first Matron. Over the years the volume of activities expanded to the degree that the Association found it difficult to manage on its own. The State Government then took over the activities and formed the State Nursing Services in 1947. Initially the Superintendent of Nursing Services worked within the Public Health Department. Later an Assistant Director (public health) post was created to look after the nursing services. The first Graduate Nursing College was started in Bombay as late as in 1960. As a consequence the nurse trainees did not have to travel outside the State. In 1964 a nursing college was started for offering Degree Course (B.Sc. Nursing) under SNDT University in Mumbai. This Programme was recognized by Indian Nursing Council in1969. The same college also started the M.Sc. Nursing course in 1976 (Rustomfram, N. 1999).

Nursing Issues in Public Sector hospitals
At present the nursing staff role functions at public sector hospitals across the different categories are not very clear. At the hospital level there is a lack of clear job descriptions. There is no uniformity in rules and regulations governing the nursing staff across the country. Nursing staff have not been provided with opportunities for their regular in-house as well higher studies. There is a lack of work standards for the nursing staff to follow or regulate the nursing care at the hospital level or at a different level. It is essential for all of us to remember that the learning process is continuous even while in service - through observation, reflection and analysis. The nursing staff lacks maturity which leads to nonproductive professional, social and cultural involvement.

Today nurses are the direct care providers, and as such are constantly under threat, from some deadly disease like the HIV/ AIDS, infections, or violence from patients under psychiatric treatment or any gender based violence. While imparting dedicated service it is imperative for nurses to safeguard their own health. Work
place environment is becoming increasingly stressful due to work place violence, over work pressure, pressure to act illegally or unethically and discrimination against co-workers. Factors contributing to these pressures are balancing work and family, poor leadership, poor internal communication, workload, lack of management support, no recognition for achievement, insufficient resources, job insecurity, technological advances and increasingly diverse workforce. A healthy work environment is a work setting in which policies, procedures and systems are so designed that employees are able to meet organizational objectives and achieve personal satisfaction in their work.

The nursing problems are too complex and diversified as time goes; therefore they blend skills of various working groups like doctors, peer groups and technical and non technical staff to solve such complex problems. Ideally, skilled nurses' understanding, patience and positive attitude help in creating a healthy work environment for nursing practice. The shortage of nurses as publicised is a paradox in view of the findings of the Tenth Five Year Plan. According to the Tenth Five Year Plan Report there are about 7.35 Lakh registered nurses in India, but only about 40 per cent are in active service as estimated. Moreover, around 20,000 trained nurses become available annually the current production capacity is more than sufficient to fill up vacancies in the government set up. It is indeed sad to note that in the event of poor nurse patient ratio in most hospitals about 60 per cent of skilled nurses is without work. It is a sheer wastage of manpower that demands immediate attention. The apparent shortage is actually due to non-creation of desired posts and non filling of vacant positions.

2. RATIONALE FOR THE STUDY

In 2006, the World Health Organization (WHO) identified the global health workforce crisis, including the critical shortage of nurses, as a priority item for action. As recently as 12 May 2007, based on the conviction, supported by evidence, those quality health care workplaces provide quality patient care, the International Council of Nursing (ICN) launched a global call to address and improve the serious deficiencies currently existing in the health work environment in all regions. The reasons for the health care and nursing crisis are varied and
complex, but evidence underlines that unhealthy work environments are key among them. Unhealthy work environments such as long hours, hazardous or unclean surroundings, over crowding, insufficient breaks, poor interpersonal relations, friction and conflict accompanied by a low professional status affect nurses’ physical and psychological health. There is increasing concern that work environment issues have affected nurses’ organisational and professional commitment. (ICN/FNIF Report, 2007) and contributed to a breakdown of the psychological contract between employer and employee (ICN/FNIF Report, 2007). Evidence indicates that “long periods of job strain affect personal relationships and increase sick time, conflict, job dissatisfaction, turnover, and inefficiency” (ICN/FNIF Report, 2007, Thomas Lund, Merete Labriola, Karl Bang Christensen, Ute Bültmann, and Ebbe Villadsen). Nurses who are stressed because of heavy workloads, friction with colleagues, inappropriate tasks, insufficient skills and knowledge, poor management or unsafe working conditions are challenged to provide the highest standards of care. In ICN’s comprehensive examination of the nursing workforce crisis – the Global Nursing Review Initiative – positive practice environments and organisational performance together emerged as one of five global priorities for action. It is necessary for the hospitals to practice positive work environment. In the absence of positive practice of work environment the employees tend to lose their professional identity and are unable to perform up to the expectations of patients as well as professional norms.

In light of the ongoing shortages of nurses and other health personnel, several studies have examined the quality of the work environment in hospitals and explored those factors that seem to foster job satisfaction. In general, these studies have confirmed the need to improve the working conditions of staff nurses and have drawn attention to the importance of such factors as nurse-patient ratios, support services, involvement in decision making level of compensation, amount of paperwork, opportunity for professional development, and respect received from hospital management and physicians.

Nursing is an important core service of any hospital. It is a fact that the organisation will need to invest in developing the environment where the nurses are competent
enough to take care of a variety of patients’ needs. The organisation must lead in
developing a climate for skill development and appropriate behaviour of the staff
whereby the quality of care is improved. Higher level administrative policies and
legislation can provide incentives for health care personnel to keep their knowledge
and skills up-to-date and they can expand opportunities for continuing education.
Organisational support to nurses to make such changes may also be needed. A
health care system that proposes to engage in total quality management should have
mechanisms built into the management structure at all levels including nursing
which help anticipate the implications of new policies for maintenance and
improvement of quality of health personnel in the system. Such initiatives need to
be reviewed with the explicit goal of determining the educational and other resource
needs of nursing personnel to deliver quality care given the new circumstances with
appropriate competency. Creating work environments that support manageable
patient workloads and levels of complexity is likely to decrease nurses’ emotional
stress level and enhance affective states and traits (Roseanne C.Moody and Daniel
J.Pesut, 2006). Public sector hospitals particularly BMC peripheral hospitals cater
large number of population. These hospitals are affected by various factors such as
financial constraints, lack of infrastructure, lack of skill and committed
professionals, shortage of staff, high expectations of patients and others. The public
sector hospitals’ service quality has been deteriorating over a period of time. Hence
the purpose of this study is relevant and important for effective delivery of
healthcare in the present and the future.