CHAPTER-I  
BACKGROUND AND METHODOLOGY OF STUDY

1.1 Introduction

Public Administration is an activity common to all countries and all levels of government. The global expansion of public related functions and services has made the role of Public Administration as highly important and significant, thus making it a complex and specialized discipline of enquiry.¹

The basic concern of Public Administration as a study includes: structure of public organizations dealing mainly with the way executive organizations are formed, readjusted and reformed, administrative process denoting the dynamic aspect of organization such as communication, control, decision making and bureaucratic behavior with emphasis on the interpersonal and intergroup relationship in organizational settings. The real core of Public Administration is not the method of management, but the services that are provided or rendered, e.g. education, health, preservation of order and so on.²

However, in present time the modern Public Administration is operating in all together the new settings and environment and facing challenges of globalization, liberalization and privatization. Public Administration today, has been open to challenges of the market and facing tough competition, through fast scientific and technological development. The expectations of the citizens have peaked very high; virtually each one of us expects almost everything from the administration, thereby having high dependence on the activities and performances of the administration, thus there is a growing pressure on Public Administration which in turn demands that it should be responsible and transparent, and above all citizen centric.³

The above mentioned pressure calls for scientific investigation to be made in the diversified operational field of Public Administration. The policies of the government and their implementation, examination of the delivery system and the satisfaction of the people, who receive the services are some of the major areas, which need to be investigated in the present era, because it is the society, whom the administration serves.⁴

Public administration of any state or country has a responsibility to meet the health needs of the citizens. Health administration is an integral part of the public
administration, which deals with every aspect of the people’s health related to health promotion, preventive services, medical care, nursing care, rehabilitation, medical education and delivering the health care through health care agencies.\(^5\)

Health care agency is the major social and organizational setup committed to provide health care services to sick and needy persons.\(^6\) A broad variety of health care services are available to patients, depending upon the nature and extent of a health problem. Traditionally hospitals have been the major health care agencies of the health care system. The hospital is basically a caring institution, which deals with the illness, suffering, pain, misery, health, welfare and life of human beings.\(^7\)

Hospitals are constituted by a variety of professional and auxiliary personnel. Nursing is a major component of any hospital and nurses make up the largest employment group within these institutions. Nursing services are necessary for virtually every patient, seeking health care of any type, including health promotion, diagnosis, treatment and rehabilitation. Nursing care is such an important part of any hospital that success of any such institution depends upon nurse’s participation in delivering quality patient care, which is an important determinant of overall patients’ satisfaction with healthcare.\(^8\)

A nurse is a health care professional, who along with other member of health care team is responsible to deliver interventions for both health promotion and disease prevention for healthy and curative and rehabilitative interventions to sick and injured people in a wide range of health care settings.\(^9\) Nurses provide care for people in the midst of health, pain, loss, fear, disfigurement, death, grieving, challenges, growth, birth and transition on an intimate front-line basis. Therefore, nurses are the persons who are responsible for providing care to the people from womb to tomb (Benner and Wrybel, 1989).\(^10\)

Nursing has been considered the oldest of the art and the youngest of the profession. Nursing care is extremely important for a good patient outcome, while physicians plan the treatment and perform the diagnostic and treatment procedures, it is the nurses who spent more time with patient for caring and looking after of all his needs throughout the hospital stay. The success of patient care and the reputation of the hospital largely depend upon the extent of efficiency of nursing care being provided by the nursing staff. Ensuring high level of nursing care is therefore a big challenge for the administration.\(^11\)
Nursing care administration is an integral part of any health care organization that strives to provide effective nursing care and ward management to ensure a quality nursing care and comfortable stay of patients in hospital wards. Nursing care administration has taken all the principles and practices, available and suitable from the parent body of Public Administration. The principles of public administration are generic and nursing care administration is just one field where these generic principles have been applied. Nursing care administration combines the perspective of nursing care with the methods of administration. The practice of nursing care administration focuses on the administration of organized nursing care services to various groups of patients for the purpose of delivering a quality nursing care.\(^{12}\)

Nursing care administration includes the nursing administration and ward management to deliver high quality of nursing care. Traditionally, the purpose of nursing administration has been to design, manage, and facilitate patient care delivery. Nurse administrators assume leadership roles in planning, organizing, and implementing care for people across the broad spectrum of health care settings. The aspects of quality outcomes, staff development, care management, strategic planning, and research are within the conceptual framework of nursing administration.\(^{13}\) Ward management is another component of nursing care administration, which includes management of the ward structure (anatomy) and functions (physiology). Structure or anatomy of the ward consists of ward layout, supportive service area, ancillary area, and miscellaneous facilities of the ward. Physiological process or functional component of a ward may include care practices and management of ward environment like proper ventilation, temperature control and infection control etc.\(^{14}\)

Satisfaction can be defined as the extent of an individual's experience compared to his or her expectations.\(^{15}\) Patient satisfaction is defined as an extent to which patient's expected health care needs are met in a hospital, which is one of the most important outcome criteria for a health care organization (Hinshaw & Atwood, 1981). Patients' satisfaction is related to the extent to which general health care needs and condition-specific needs are met.\(^{16}\)
Nursing care practices are patient driven and patient centered. A patient constantly interacts with nurses throughout his/her stay in the hospital. Therefore, patients' satisfaction with health care facilities largely depend on nursing care received and kind of ward facilities/services experienced. Satisfied patients are more likely to comply with the treatment and therefore ought to have a better health outcome. Patient satisfaction data can help to identify ways of improving nursing care practices and ward facilities/services, which will ultimately lead to better quality care and happier patients with better health outcome. (Lin CC, 1996). Patients’ satisfaction is thus a key sensitive nursing care outcome indicator to analyze quality of care provided to patients (Morin, 1999). Therefore, patients’ satisfaction have been strongly advocated by nursing professionals to be an important indicator of nursing care quality and the type of health care facilities/services being provided.

The forgoing discussion clearly established that there are certain pertinent emerging issues needed investigations like: What is the current status of nursing administration? How wards are managed? What is state of patients’ satisfaction with facilities/services and nursing care in selected government and private hospitals? Therefore, this study was planned to provide comprehensive data to planners, administrators, organizers, and authorities, researchers regarding available basic facilities, manpower for providing nursing care, management of hospital wards and patients’ satisfaction with ward facilities/services and nursing care.

1.2 Health care in India

It is the lack of resources and absence of commitment that plague the health care in India. The nation still spends less than one percent of the GDP on this sector. Look at the public and private health care system in the country, where the rich have access to state-of-the-art hospitals, while the poor have nowhere to go. What is the health seeker’s level of satisfaction with the existing nation’s health care services? Is yet to be unfolded (Amartya Sen, 2005).

Health care facilities and personnel increased substantially between the early 1950s and early 1980s, but because of fast population growth, the number of licensed medical and paramedical personnel per 10,000 individuals have fallen by the late 1980s to three per 10,000. In 1991, there were approximately ten hospital beds per 10,000 individuals. In 1991, India had about 22,400 primary health centers, 11,200 hospitals, and 27,400 dispensaries. According to data provided in 1998 by the
Ministry of Health and Family Welfare, Government of India, the total number of civilian hospitals for all states and union territories is; 10,157, with a total of 811,000 health care facility beds.22

There is a growing need of more health care facilities, as population in India has crossed one billion figures (1.13 billion as per National estimation for March 2008). India spends only one percent of its GDP on health, translating into $35 per capita. France spends 10.4 percent and Japan 8 percent. A significant portion of the population receives inadequate or no healthcare, specifically 25.7 percent living below the poverty line and those who have only the public health system to rely upon.23

According to the recently released Planning Commission report (June, 2007), India is in short of a phenomenal 600,000 doctors, one million nurses and 200,000 dental surgeons. With positions for 300,000 dental surgeons, only 73,000 are currently filled. Meanwhile, 1.1 million nurses are filling up vacancies for 2.1 million, a shortfall of nearly 50 percent. In other words, for every 10,000 Indians, there is barely one doctor available. These figures compare dismally with countries like Australia, which provides 249 doctors for every 10,000 people, Canada which offers 209, Britain 166 and the United States 548. Overall, Indian medical colleges currently churn out about 30,000 doctors a year, apart from 20,000 dentists and 45,000 nurses. Experts point out that the need for health care professionals is at least double of these numbers.24

Till the 1980s, government run hospitals were the main providers of health care in India. However, over the last few years there has been an increased participation by the private sector. These days private hospitals, nursing homes and clinics play a major role in administration of Indian healthcare. The public, private and voluntary health sectors together contribute towards the provision of health care in India. All these play significant roles in influencing the health status of the Indian population. But their contribution is not without shortcomings. The government intended to focus on providing better public health care facilities that is clearly evident from government’s intent to enhance the overall public health investments to 2 percent of GDP. In addition, National Health Policy 2002 (NHP 2002), that envisages an increasing role of private sector in the delivery of secondary and tertiary level care along with investments in high-end technological solutions.25
The goal of health care institute is to provide the patients with the best possible health care services. The health care providers need to have constant effort to meet the patients' needs and expectations. In the last few years the old way of treating patients in the 'disease centered' approach has changed to 'patient centered' style worldwide. Now patients have more influence toward the care they receive and even given the opportunity to change the way the care being delivered to them. Patients’ satisfaction is one of the core outcome measures for healthcare. It is intuitively more appealing than measures of health care effectiveness or efficiency that are more difficult to understand. Patients’ satisfaction with health care is a measure with a long history in the social sciences.26

1.3 Hospitals in India

The world 'hospital' is derived from Latin word 'hospice'. In fact, the world hospital, hostel, and hotel all are derived from the common Latin root hospice. Meaning of hospice is host or a establishment where a guest is received and cared. World Health Organization (WHO) defines the hospital “The hospital is an integral part of the social and medical organization, the function of which is to provide for the population, complete health care, both curative and preventive and whose out patient services reach out to the families and its environment; the hospital is also a center for the training of health workers and biosocial research”. Today, hospital means an institution in which sick or injured persons are treated and healthy persons are helped to promote and maintain an optimum level of well being. A modern hospital is an institution, which possesses adequate accommodation and well qualified and experienced personnel to provide services of curative, restorative, preventive and promotive characteristics of the highest quality possible to all people, regardless of race, colour, creed or economic status. It conducts educational and training programs for the health personnel particularly required for patient care and hospital services. It also conducts research in assisting the advancement of medical services and hospital services and conducts program of health education.

Hospitals can be classified as per ownership/ control, clinical basis, patients' length of stay and teaching or non-teaching status. As per ownership basis, the hospitals can be public, voluntary, private and corporate hospitals. The public hospitals can be further classified as central government hospital and state
government hospitals. Private hospitals can be missionary or charitable trust hospitals.

Early Indian rulers considered the provision of institutional care to the sick as their spiritual and temporal responsibility. The forerunners of the present hospitals can be traced to the times of Buddha, followed by Ashoka. India could boast of a very well organized hospital and health care system even in the ancient times. The writings of Sushruta (6th century BC) and Charaka (200 AD) the famous surgeon and physician respectively were considered for their standard work for many centuries with instructions (in Charaka Samhita) for the creation of hospitals for provisions of lying in and children rooms, maintenance and sterilization of bed linen with steam and fumigation and use of syringes and other medical appliances. Medicine based on the Indian system was taught in the ancient university of Taxila. Charaka Samhita, a treatise of surgical knowledge was compiled during 400 AD.

The most notable of the early hospitals were those built by king Ashoka (273-232 BC). There were rituals laid down for the nurses and physicians who were enjoined to wear white clothes and promised to keep the confidence of the patients. However, the age of Indian medicine started its decline from Mohammedan invasions during the tenth century. The Mohammedans brought with them their Hakims who followed the Greek system of medicine, which came to be known as ‘Unani’. The system and its physicians started to prosper at the expense of Ayurveda and its Vaidyas. However, the influence of Ayurveda continued in the south.

The modern system of medicine in India was introduced in the 17th century with the arrival of European Christian missionary in South India. In the 17th century, the East India Company; the forerunner of the British Empire in India established its first hospital in 1664 at Chennai for its soldiers and in 1668 for civil population. European doctors started getting popular and during the later part of 18th and 19th century, there was a steady growth of modern system of medical practice and hospitals, pushing the indigenous system to the background. Organized medical training started with the first medical college opening in Calcutta in 1835, followed by Mumbai in 1845 and Chennai in 1850. Thereafter, these services swelled up and in 1885, there were 1250 hospitals and dispensaries in British India. After independence time to time various committees were constituted to study the health services, these committees have recommended for increasing need of hospitals and health centers.
Today we have more than 20,000 secondary and tertiary care providing hospitals in India. However, 70 percent of the country’s health care infrastructure is under the private sector.

1.4 Health care Facilities in Punjab

a) Public Sector health care facilities

The public sector has an adequate number of health care facilities at all levels. The Government of Punjab runs 208 Public hospitals, 117 Community Health Centers (CHC), 484 Primary Health Centers (PHC), 1470 Subsidiary Health Centers (SHC) and 2852 Sub-Centers (SC). District and sub district hospitals are based in urban areas with more PHCs and SHCs based in rural areas. This results in the availability of majority of beds in urban areas. Given the ease of access and availability of transport in Punjab, even urban hospitals are easily accessible by rural population.

Table 1.1: Public health care facilities in Punjab

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Institutes</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>Hospitals</td>
<td>73</td>
<td>135</td>
</tr>
<tr>
<td>Hospitals/ CHCs</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>CHCs</td>
<td>35</td>
<td>20</td>
</tr>
<tr>
<td>CHC/ PHC</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>PHCs</td>
<td>422</td>
<td>24</td>
</tr>
<tr>
<td>SHC/ dispensaries</td>
<td>1,220</td>
<td>250</td>
</tr>
<tr>
<td>Total</td>
<td>1,776</td>
<td>453</td>
</tr>
</tbody>
</table>


Punjab’s public sector health care service infrastructure is considered better than other Indian states, as its adequate in comparison to that of other Indian states. Moreover, the public sector alone is able to meet WHO norms of providing one bed per 1,000 population. With an additional 16,000 beds available in private sector; the state comfortably meets reasonable expectations for the infrastructure provision at an aggregate level. We have no information on the quality of the infrastructure available in the public and private sector. Health care professionals are highly concentrated in certain areas. There are close to 16,000 registered doctors (1/1,472 people) supported
by a further 21,000 midwives and 12,000 nurses. However, these health care professionals are heavily concentrated in certain areas such as Amritsar, Patiala, Ludhiana and Jalandhar. Other districts such as Muktsar, Moga, Mansa and Nawanshahr are extremely poorly served. This pattern is repeated with respect to private facilities too.

b) Private sector health care facilities

Private sector health care facilities are heavily concentrated in urban areas despite of being a home to only one third of the total population. Two-thirds of the State’s 206 urban private sector hospitals are found in just 2 (Ludhiana & Jalandhar) of the 17 districts of Punjab. Rural areas and districts close to the border of Pakistan have fewer private facilities at all levels. As one would expect, a higher proportion of lower level facilities than urban area also marks rural areas.

<table>
<thead>
<tr>
<th>Type of private facilities</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>206</td>
<td>35</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>597</td>
<td>61</td>
</tr>
<tr>
<td>Poly Clinics</td>
<td>76</td>
<td>10</td>
</tr>
<tr>
<td>Clinics</td>
<td>2,554</td>
<td>384</td>
</tr>
<tr>
<td>Dispensaries</td>
<td>37</td>
<td>16</td>
</tr>
<tr>
<td>Others</td>
<td>37</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>3,507</td>
<td>524</td>
</tr>
<tr>
<td>Total private beds</td>
<td>15,004</td>
<td>1,018</td>
</tr>
</tbody>
</table>

Source: Survey of private practitioners in Punjab, Foundation for research and development of underprivileged group.

Most of the facilities are owned by an individual or single family. Only 5 percent of such facilities form part of chain of two or more facilities under the same management. According to a recent survey of private practitioners, these private facilities account for almost 8,000 doctors. Eighty-six percent of these doctors are full time staff with the remainder made up of part time and visiting staff. The Majority of private sector doctors are general practitioners operating in clinics. The specialties are concentrated in few areas including; medicine, eye, obstetrics, and gynecology and
dentistry. The large number of obstetricians and gynecologists in the private sector are mirrored by shortage in the public sector, which deters many women from seeking institutional deliveries in public sector. Although the majority of private facilities offer allopathic services, other systems of medicine are mixed with allopathy in 28 percent of private facilities and this figure rises to 49 percent of facilities in rural areas where Ayurvedic, Unani and Homeopathy are popular.

1.5 Health Seeking Behaviour of People in Punjab

The majority of people in Punjab seek health care from the private sector. According to NSS data (1995-1996), about 86 percent of OPD patients are catered in the private sector. A further nine percent patients attended public as well as private health care facilities. A similar pattern emerges with respect to in-patient care where the private sector also dominates the public sector. Even for those below the poverty line, 56 percent are treated as in-patient in the private sector. Almost a quarter of towns and half the villages in Punjab only have private health care facilities forcing those that seek public sector medical treatment to travel further. The poor in Punjab are overwhelmingly likely to use the private sector for healthcare. According to NFHS-2 data, even among the poorest group, only 16-17 percent utilize public facilities, whereas 82-83 percent of them are seeking their health care services from profit making private health care sector. This overwhelming use of private health care facilities in Punjab could be because of either non availability of satisfactory government health care services in near reach of people or services are not good enough to satisfy the consumers that force them to seek their health care from private sector. The ESI provides health insurance to 383,000 formal sector workers in Punjab. The scheme is mandatory for employees earning up to rupees 6,500.\textsuperscript{30}

1.6 Patients’ Satisfaction: Meaning

Patients’ satisfaction is commonly used to measure how well health care providers are meeting the needs of their patients. Donbedian states that, satisfying patient is one important indicator of quality care, because it demonstrates the ability of the providers to meet expectations and values of the patient.\textsuperscript{31} Hospital industry report on managed care organizations include patients’ satisfaction as one of the measure of service quality.\textsuperscript{32} However, the science of measuring patients’ satisfaction is yet in its infancy.\textsuperscript{33}
Satisfaction, like many other psychological concepts, is easy to understand but hard to define. The concept of satisfaction overlaps with similar themes such as happiness, contentment, and quality of life. Satisfaction is not a pre-existing phenomenon waiting to be measured, but a judgment that people form over the time passage of as they reflect on their experience. A simple and practical definition of satisfaction would be the degree to which desired goals have been achieved.\textsuperscript{34}

Olive (1997)\textsuperscript{35} defines satisfaction as “an individual’s judgment about extent to which a product or service provides a pleasant level of consumption-related fulfillment. Stated simply, satisfaction results from an evaluation of a product or service that meets some emotional reaction. A judgment is made by an individual as to how well the services were provided, and this judgment results in pleasure, if satisfaction occurs or displeasure if dissatisfaction occurs.

Nair KG (2004)\textsuperscript{36} also discussed meaning and need of patients’ satisfaction. Patients’ satisfaction is a person’s feeling of pleasure or disappointment resulting from comparing a product/ service’s perceived performance or outcome in relation to his or her expectations. As this definition makes clear, satisfaction is a function of perceived performance and expectations. If the performance falls short of expectations, the patient is dissatisfied. If the performance matches the expectations, the patient is satisfied. If the performance exceeds expectations, the patient is highly satisfied or delighted. It is the ability of hospital services to meet the expectations of the patients. Patients delight is all about exceeding the expectations to make him highly satisfied with the hospital. The hospitals should aim for high satisfaction of patients because satisfied patients are more likely to comply with treatment, take an active role in their own care, and therefore ought to have a better outcome.

Patients’ satisfaction with nursing care can be defined as a patient’s opinion of care received from nursing staff during the hospital stay, as determined by scaled responses to a uniform series of questions, designed to elicit patients’ views regarding satisfaction, with key elements of nursing care services. Ware et al (1983)\textsuperscript{37} also defined patients’ satisfactions as patients’ attitude towards health care received by them.
Table 1.3: Conceptualization of satisfaction

<table>
<thead>
<tr>
<th>Conceptualization</th>
<th>Focus</th>
<th>Strength</th>
<th>Weakness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance evaluation</td>
<td>Salient characteristics of a service</td>
<td>Can evaluate specific characteristics of a service</td>
<td>Characteristics are selected by researcher and might not be reflective of individual views</td>
</tr>
<tr>
<td>Disconfirmation of expectations</td>
<td>Cognitive appraisal of a service experience</td>
<td>Provide understanding of the psychological process of service evaluation</td>
<td>Results are sensitive to the type and level of expectations used for study</td>
</tr>
<tr>
<td>Affect-based assessment</td>
<td>Emotional response to a service and resultant action by the individual</td>
<td>Allow the investigation of the emotional responses to services especially in the absence of prior expectations</td>
<td>Might be applicable to short term evaluation but not to long term evaluation</td>
</tr>
<tr>
<td>Equity-based assessment</td>
<td>Fairness in what is gained compared with what it cost the individual</td>
<td>Allow investigation of the relationship between input and output of the individual and the services provided</td>
<td>Assessment that fairness is the key determinant of satisfaction</td>
</tr>
</tbody>
</table>

Satisfaction is not to be confused with dimensions of quality such as 1) quality of performance or 2) quality of design. Quality of performance is the consistency of how the product is manufactured or the service delivered. For example, nursing care practices of a hospital meets all the laid down standards of the national statutory nursing body. Every nursing procedure is practiced as prescribed protocols of the organization or national statutory nursing body. Quality design is how well the product or service is as compared to other similar available competitor organizations. In contrast, to how quality is measured and evaluated, satisfaction is specific to the individual and is based on the perception and judgment of individuals. It follows, then
that patient’s satisfaction is an individual judgment about the extent to which a health care product or a service provides a pleasurable level of consumption related fulfillment. In the recent literature, satisfaction has been conceptualized in four ways; 1) performance evaluation, 2) disconfirmation of expectations, 3) affect-based assessment, and 4) Equity-based assessment (Table 1.3).

**a) Satisfaction as performance**

Patients’ satisfaction can be viewed as a personal evaluation of health care services and providers. Ware and colleagues developed the patients’ satisfaction Questionnaire (PSQ) using a performance evaluation approach. In such an approach, service characteristics are divided into categories (e.g. Interpersonal characteristics, accessibility etc.). Then, individual are asked to respond to each statement about the service on a Likert-type scale usually ranging from “strongly agree” to “strongly disagree.”

Ware and colleague viewed patients’ satisfaction as a multidimensional construct in which distinct features of care are assumed to influence individual’s attention towards providers or services, with each of these features possibly having a different effect on satisfaction. Much of the literature on patients’ satisfaction has focused on identifying salient characteristics of health care services for evaluation by individual.

Viewing patients’ satisfaction, as performance evaluation is most useful for services that have characteristics, individual can identify and understand. However, individual might not have the expertise to assess unfamiliar or ambiguous services. In these instances, individuals might base their evaluation on their expectation of whether or not such a service should be offered to them or on how the service experiences make them feel.

**b) Satisfaction as disconfirmation of expectations**

In his conceptual article, Oliver described satisfaction as a result of one comparing an expectation to the actual service experience. This gap between the expectation and service experienced can impact how one feels about the service experience or the individuals’ satisfaction with the services. The disconfirmation of expectation model that Oliver describes in his paper has been tested and validated by
This model states that individuals compare their experiences with the services to the expectations. These expectations serve as reference point. Although many researchers have accepted this view of satisfaction, they have held different opinion about which expectations, or comparison standards, are most pertinent and about which interrelationship among variables are most important in the satisfaction.43

c) Satisfaction as affect-based assessment

Satisfaction also has been viewed as a pleasurable response to a service encountered. This type of conceptualization takes into consideration that individual with moderate expectations of health care service will likely to be indifferent if those expectations are met. However, an individual with high expectations for a health care service might be delighted if a health care provider successfully meets his high expectations. Thus, the focus in this conceptual framework is the degree of affective response and not only how well expectations were not met.44 Also, Kucukarslan, Pathak and Segal showed that this conceptual view of satisfaction can be very useful in case when individuals have no prior expectations of a health care service. In these cases, how a person feels would be an appropriate way to measure patients’ satisfaction because knowledge about the service and prior expectations about the service are absent.

d) Satisfaction as equity-based assessment

A fourth conceptualization of patients’ satisfaction is an equity-based assessment. This is a comparison of one’s outcome versus input. The resulting perception of fairness has a direct relationship to satisfaction. Individuals who perceive that a service provider has gained more than they have are likely to be less satisfied. Studies show that perceptions of fairness increases as the difference between input and output increased in favour of the individual.45

When including patient satisfaction mechanisms in health care systems, the options should take an account of capacity of the users to understand what is being asked from them and to communicate their opinions and feelings effectively. Important factors influencing patients in this regard include literacy levels, intellectual and physical/ sensory disability levels and difficulties with language proficiency or
ethnic and cultural diversity. Social elements within our society must be considered as they can very often dictate whether the consumer will provide feedback and express their satisfaction or otherwise, e.g., financial status, educational status, demographics, technology. Previous measurements of patient satisfaction overwhelmingly show that the majority of consumers, usually 80 percent or more, express overall satisfaction with their care, with few respondents responding negatively to any given item. Satisfaction is, however, a relative measure, which research literature shows, may be influenced by many factors.46

Finally, when comparing satisfaction among group of individuals who belong to different health plan or access different care providers within health plan. It is important to control for case mix. Case mix refers to the different patient attributes that might be apparent in different settings. To the extent that patients self selected or are assigned to different comparison groups in nonrandom way, comparison of satisfaction rating may be biased by factors other than provision of the health care services in the compared groups.47 For example, when relationship between health status and comparing patients’ satisfaction have been reported. Thus, it is often prudent to control for the effects of health status when comparing patients’ satisfaction between groups. Other factors might account for differences in satisfaction score depending on the questions being addressed in the study. Case mix control variable such as age, gender, socio-economic status, disease severity, physical functioning, service expertise, or service providers’ familiarity also should be considered for inclusion in the study. Methods used to control or adjust for case-mix variable can be used (e.g. Restriction, stratification, matching, and statistical adjustment).48

Figure 1.2 depicts a composite Cognition-Affect model of satisfaction as proposed by Oliver. Cognitive antecedents include expectations, performance, disconfirmation, attribution and equity/inequity. Expectations and performance may exert a direct effect upon satisfaction or may be mediated indirectly through the process of disconfirmation. Affect, both positive and negative, is seen as another intermediary between both performance and attribution. Equity is postulated as a further distinct contributor to satisfaction, unrelated to affect or other cognitive components.
1.7 Patients’ Satisfaction: Importance

Kumar R (2003)\textsuperscript{49} mentioned that improved socio-economic status and easier access to medical care has led to high expectations and demands from the consumer of health care services. Health care services at public and private hospitals have been under increasing strain to meet the expectations particularly because the health care has come to the ambit of "service" under the "Consumer Protection Act." This has necessitated the regular monitoring of the quality of services in the hospital by the management. Assessment of care adequacy must go beyond the usual measures of structure process and outcome variables to include consumer evaluation of quality as well, indeed, any evaluation of care outcomes may be incomplete without including outcomes as perceived by the patients. It has been suggested that patients’ satisfaction is a potentially important factor in health care as it may influence whether or not a patient seeks medical care complies with treatment and maintains a continuing
relationship with the providers. It was added that assessment of patients’ satisfaction should be a regular phenomenon, which can be used as one of the Total Quality Management (TQM) indicators and helps the management to improve the services.

In recent years, there has been an increase on the emphasis of patients’ satisfaction by health care organizations and providers. Why is this so? This has happened, at least in part, because of the emerging body of research that has established relationships between patients’ satisfaction and other key concepts in health care. For example, we have learned that satisfaction is related to many important health behaviors such as better compliance to treatment, better health care outcome that leads to healthy and happier patient and community. Aharony and Strasser (1993) observed that other researchers made the following conclusions regarding importance of measuring patients’ satisfaction. They mentioned that satisfied patients are:

♦ more likely to continue using health care services.
♦ maintain a relationship with a specific health care provider.
♦ comply with medical regimens (including medications).
♦ participate in their own treatment.
♦ cooperate with their health care providers.

Aharony and Strasser (1993) concluded that “while research has not yet found a simple, direct correlation between patients’ satisfaction and improved outcome, satisfied patients seem more likely to comply with their treatment. Levels of patients’ satisfaction and patient compliance are presumed to subsequently affect other outcomes, such as the patient’s health status, continuity of care, and the frequency and length of hospitalization.

1.8 Nursing/ Nursing Care: Meaning

Nursing is an art and a science, which evolved from an unstructured method of caring for the ill to a scientific profession. Florence Nightingale defined nursing over 100 years ago as “the act of utilizing the environment of the patient to assist him in his recovery” (Nightingale, 1860). Nightingale considered a clean well ventilated and a quite environment essential for recovery. Virginia Henderson was one of the first modern nurses to define nursing. In her words “Nursing is the unique function of the nurse is to assist the individual, sick or well, in the performance of those activities
contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge and to do so this in such a way as to help him gain independence as rapidly as possible.” (Henderson, 1966). Like Nightingale, Henderson described nursing in relation to patient and patients’ environment.

In 1987, the Canadian Nurses Association (CNA) described nursing practices as a dynamic, caring, helping relationship in which the nurse assists the client to achieve and obtain optimal health (CNA, 1987). In 1980, American Nurses Association also defined nursing, stating that “Nursing is the diagnosis and treatment of human responses to actual or potential health problems” (ANA, 1980). In later half of the 20th century, a number of nurse theorists developed their own theoretical definitions of nursing. Theoretical definitions are important because they go beyond simplistic common definitions. They described what nursing is and the interrelationship among nurses, nursing, the clients (patient, family and community), the environment and the intended client outcome: health.

Nursing is a health care profession focused on the care of individuals, families, and communities so that they may attain, maintain, or recover optimal health and quality of life from birth to the end of life.

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

Certain themes are common to many of the these definitions: Nursing is caring, Nursing is an art, Nursing is a science, Nursing is client centered, Nursing is holistic, Nursing is adaptive, Nursing is concerned with health promotion, health maintenance and health restoration and Nursing is a helping profession.

1.9 Recipient of Nursing Care

The recipient of nursing care sometimes called consumers, sometimes patients and sometimes clients. A consumer is an individual, a group of people, or a community that uses a service or commodity. People who use health care products or services are consumers of health care.
A patient is a person who is waiting for or undergoing medical treatment and care. The word patient comes from a Latin word meaning “to suffer” or “to bear.” Traditionally, the person receiving health care has been called as patient.

Nurses interact with family members, and significant others to provide support, information, and comfort, in addition to caring for the patients. For these reasons, nurses increasingly refer to recipients of health care as client. A client is a person who engages the advice or services of another who is qualified to provide this service. The term client presents the recipient of health care as collaborators in the care, that is as people who are also responsible for their own health. In this thesis the term patient is mainly used for care recipient, although clients and consumers were also used in some instances.

1.10 Literature Review

Patients’ satisfaction is one of the core outcome measures for health care services. It is intuitively more appealing than measures of health care effectiveness or efficiency that are more difficult to understand. Patients’ satisfaction with health care is a measure with a long history in the social sciences. Since patients’ satisfaction is a vital variable of health care services, a lot of literature is available in the form of books, published and unpublished thesis, research articles in journals, official documents etc. Following literature has been reviewed to get insight in health care services and patients’ satisfaction. Before we embark upon description under the above head, we may mention that it is not possible to survey the entire literature but we could make only a brief survey of limited and vital literature.

a) Patients’ satisfaction with nursing care

Evaluation is one of the most critical phases of the nursing process because it supports the basis of the usefulness and effectiveness of nursing practice. Nursing practice is patient driven and patient centered. Accordingly, patients’ satisfaction has been strongly advocated by nursing professionals to be an important indicator of quality of nursing care delivery. Satisfied patients are more likely to comply with treatment and therefore ought to have a better health outcome. Patients’ satisfaction, data can help to identify ways of improving nursing care practices, which will ultimately, lead to better quality care and happier patients with better health outcome (Lin CC, 1996).
Indian literature

A study was conducted by Dorcas Hemrom (1974) to determine the satisfaction and dissatisfaction expressed by the elective surgical patients and their relatives with nursing care in CMC hospital, Vellore. Total 50 patients/relatives were interviewed; findings revealed that patients were more satisfied with post-operative services than preoperative nursing care. Patients expressed higher degree of satisfaction with physical aspect of nursing care, however, they were dissatisfied with communication, and emotional support extended by nurses. It was further added that migrants were more dissatisfied as compared to local people.

E.S. Praba (1988) conducted a study of factors related to satisfaction and dissatisfaction experienced by mothers of the hospitalized children about diet. Study findings revealed that 68 percent of the mothers were not satisfied with hospital-supplied diet, while 32 percent were satisfied with it. Main reasons of dissatisfaction for hospital diet were lack of test (52.9 percent) and poor preparation (47 percent). In addition, it was also found in majority of the observations taken up at breakfast (70.2 percent), at lunch (75.5 percent) and at dinner (33.1 percent), that the children ate less than one half portion of the supplied diet.

Munni Dhar (1989) conducted a study to identify the postnatal mothers’ satisfaction with nursing care in a selected government maternity hospital at Srinagar. Satisfaction was measured among 80 conveniently selected postnatal mothers regarding selected nursing care variables like reception in the ward, comfort, hygiene, observation, diet, environment, psychological support, care of baby, health teaching and discharge. Satisfaction was measured on three categories; satisfied, partially satisfied, and least satisfied. Finding revealed that 47.5 percent subjects were satisfied, while 16.3 percent were least satisfied. The area of high satisfaction was comfort, psychological support, environment and reception in ward. The area of low satisfaction was hygiene, care of baby, health teaching and discharge planning. It was added that there was no significant relationship between satisfaction score and mother’s background variables like socio-demographic characteristics, length of hospital stay, previous experience of hospitalization and history of cesarean section.

Pratima Rao (1991) conducted a case study on hospital service administration at Safadajung Hospital Delhi. It was reported in the study that there was shortage of nursing staff. Hence, due to shortage, overworked nurses were not able to provide quality patient care. Except providing injection and medication and
assisting doctors; no other services were provided to the patients. Patient’s relatives actually did tasks of nursing. Further patients in every ward were complaining for lack of equipments and stinking toilets.

Poonam Joshi (2002) conducted a study to find out the level of parents’ satisfaction with paediatric nursing care, whose children were admitted in paediatric units of selected government hospital at Delhi. It was revealed that 51.4 percent parents were highly satisfied with nursing care provided to their children, rest of them were moderately satisfied. Areas of high level of satisfaction in the paediatric nursing care were the environment, comfort, rest and sleep, psychological support and the diet. The areas of least satisfaction were elimination, play and activity, participation in care and personal hygiene. In addition, parents suggested that nursing personnel needs improvement in communication skills (22.7 percent), providing psychological support to the parents (16.7 percent) and health education (8 percent). No significant relationship was found between educational qualification of parents and satisfaction score. However, significant relationship was found between satisfaction score and their child’s length of hospitals stay.

R. K. Sharma (2004) conducted a study on patients’ satisfaction in a zonal hospital at Mandi, HP, India, who have considered a variable, patients’ satisfaction towards nurse’s behavior and found that four percent patients were highly satisfied, 20 percent were just satisfied, whereas, rest 64 percent patients were quite dissatisfied towards the behavior of nurses.

Kapzawni (2004) conducted a study to identify the postnatal mothers’ satisfaction with postnatal nursing care in selected hospital at New Delhi. It was found that only 10 percent of the mothers were satisfied, 74 percent were partially satisfied. However, 16 percent of the mothers were completely dissatisfied. Postnatal nursing care areas of maximum satisfaction were comfort and safety, treatment, psychological support. Least satisfaction areas were health teaching, care of newborn and hygiene. In addition, education, family income and sex of newborn have made no difference in satisfaction level of mothers with postnatal nursing care. However, parity and mode of delivery had significant relationship with mothers’ satisfaction, where multiparas were more satisfied than primiparas, and mothers with caesarean section were more satisfied as compared to vaginal delivery.

Sushma kumari (2005) conducted a study on nursing services in selected hospitals of Punjab, Haryana and Chandigarh, the researcher included patients’
satisfaction with nursing care as a variable and found that satisfaction of patients with nursing care was very high in all the three selected hospitals (autonomous, state government & private) as majority of the patients (>90 percent) were satisfied or highly satisfied with nursing care. It was further added that males, young patients from rural background and with Muslim/Christian religion, primary education and self employed were satisfied or highly satisfied as compared to their counterparts.

Ranjitha Rajesh (2006)\textsuperscript{62} conducted an exploratory study to assess the level of satisfaction with nursing care services provided to Bhopal gas victims seeking outdoor and indoor services from a selected hospital at Bhopal. Study findings revealed that 12 percent patients were satisfied with nursing care received, while 43 percent were fairly satisfied. However 45 percent of them were dissatisfied with nursing care received by them. Least satisfaction area was found to be physical care and areas of highest satisfaction were found to be with health education and spiritual care. In addition, no significant relationship was found between patients’ satisfaction and their age, gender, marital status, income, occupation, educational status and type of illness.

Achala (2007)\textsuperscript{63} conducted a study to assess the level of parents’ satisfaction with paediatric nursing care, whose children were admitted in paediatric units of selected government hospital at Delhi. It was revealed that majority of parents i.e. 94 percent were satisfied with nursing care (2.7 percent fully satisfied, 34.7 percent satisfied and 56.7 percent partially satisfied), while six percent of them were dissatisfied with nursing care. It was added that the highly satisfying paediatric nursing care areas were environment (68.1 percent), comfort, rest and sleep (67.4 percent), admission (64 percent) and nutrition (62.9 percent). The areas of lower level of satisfaction were family involvement in care (52.8 percent), play and activity (52.3 percent), observation (51.4 percent) and personal hygiene (45.9 percent).

*Western Literature*

Ventura Marlene R *et al* (1981)\textsuperscript{64} evaluated the effectiveness of primary care nursing by using Riser Patient Satisfaction Scale (RPSS). Forty-six patients from two units completed the questionnaire. A great majority of patients showed high level of satisfaction but the mean difference of the patients’ satisfaction score between units where primary nursing was instituted and the control units showed no significant
difference on total score or score of subscales i.e. technical professional, interpersonal education and interpersonal trusting.

Sellick Kenneth J et al (1983) evaluated the effect of primary nursing on patients’ satisfaction. Primary nursing is an organized system of care, which emphasizes on the delivery of comprehensive, individualized, and continuous nursing care through the nurse with the authority and autonomy to plan and implement such care. Study was conducted in a large acute medical and surgical hospital in Melbourne. Two general wards were selected. Twenty-eight patients with minimal length of stay of 4 days completed patient satisfaction questionnaire. Results indicated that patients nursed under a system of primary nursing reported greater satisfaction with care they received than nursed under a traditional system. Statistically significant differences between two groups in favour of primary nursing care were evident on six of 11 items, which examined patients’ perception of care. Detailed examination of items which were significantly different indicated that nurses in the primary nursing unit were perceived to have greater understanding of patients; showed more concern and communicated more with the patients’ family; were more likely to give information to patient regarding his/her illness or tended to contribute more to a positive experience of hospitalization and gave greater consideration to discharge planning.

Erler Cheryl (1989) investigated the patients’ satisfaction with nursing care given during twelve-hour shift verses traditional eight-hour shift. Study results indicated that patients’ satisfaction with nursing care during a twelve-hour shift did not differ from satisfaction with nursing care during traditional eight-hour shift. This can be considered as determining factors in deciding to adopt flexible scheduling. Findings of the study also indicated no significant relationship of the study variables to any of the demographic variables.

Zahr Lina Kurdahi et al (1991) studied patients’ satisfaction with nursing care in Alexandria, Egypt using La Monica Oberst patient satisfaction scale. A total of 35 medical and 35 surgical patients were studied and found that the mean total score of respondents was 256.36 ± 42.34 (maximum possible of 287), which showed that patients’ satisfaction was high. There was no significant difference between patients’ satisfaction score on medical and surgical unit. In general, most patients (75 percent) indicated that they were satisfied with nursing care. Patients in 40-50 years age group were significantly more satisfied with the nursing care they received than older or
younger clients. Male patients and patients with primary education were more satisfied with nursing care than others.

A study conducted by Aharony L and Strasser S (1993) on patients’ satisfaction at Community Cancer Center in Manchester, UK reported to have high degree of patients’ satisfaction with the nursing care. The satisfaction variables with nursing care were nursing staff friendliness, explanation of procedures, sensitivity to needs, and quality of care.

McNamee Suzanne (1995) conducted a patient satisfaction survey on 65 inpatients of the cardio thoracic ward. Results indicated that 66 per cent subjects found that preadmission clinic was helpful, as it dispelled some of the fear of the unknown. Ninety three percent of patients said that they were very satisfied or satisfied with the nursing staff’s attention to their pain relief, patients’ concerns and problems during their stay. Two areas of nursing care particularly required improvement i.e. patient education on warfarin therapy and effectiveness in discharge education. A frequent complaint from patients was the unacceptable level of noise in the ward.

Wolf ZR et al (1998) conducted a cross-sectional study on 335 patients to examine patients’ satisfaction with nursing care, using the Caring Behaviors Inventory and Patient Satisfaction Instrument. A strong, positive correlation ($r = 0.78$, $p < .001$, $R^2 = 61.46$ percent) was found.

Lynn and McMillen (1999) compared 448 patients’ and 350 nurses’ ranking, in the importance of items reflective of good care in seven hospitals in the South Eastern United States. Results indicated that patient ranked professionalism higher. They valued nurses who were dedicated, efficient professional in their conduct and perceived professional care as quality care. Whereas, nurses themselves graded professionalism low in rank. Further, patient ranked aspects of care related to physical environment and psychological aspects of care higher than nurses. Nurses ranked aspects of care related to intrinsic characteristics of nursing i.e. empathy, trust, competence and things they do for patients i.e. examination and explanation higher than patients suggesting that nurses over estimated the importance of these aspects.

Kangas Sandra et al (1999) studied the organizational factors and patient satisfaction with nursing care from three hospitals representing three different nursing care delivery models, including team nursing, case management and primary nursing. A total of 102 patients were interviewed. Findings indicated that overall patients were
satisfied with nursing care. Only nursing care delivery model and length of time in the unit (inverse correlation) were significant in predicting patient satisfaction with nursing care. Patients receiving nursing care in primary care delivery model expressed more satisfaction. The longer the patients had been in the unit, the lesser was their level of satisfied. The subscale score for education indicated that patients were not satisfied with the education they received from the nursing staff.

Dingman SK et al (1999)\textsuperscript{73} compared patients’ satisfaction score six-month pre-intervention and six month post-intervention. The intervention was a caring protocol which included self introduction and role explaining, calling patient by name, and sitting at patients’ bed side for five minutes per shift to plan and review patient care, use a handshake or a touch of arm and use of mission, vision and value statement in planning care. There was a significant increase in patients’ satisfaction scores, related to nurses’ anticipation of needs and the responsiveness of nurses to requests; and the aspects of care that were designated as areas for improvement. However, authors noted that sustained efforts were needed to maintain the awareness and integration of the caring behaviour with care. One of the most powerful and simple behaviour was the nurse sitting at the bedside and taking five minutes of her time to be with the patients anticipating their needs and responding without being asked. This gave patients a powerful proactive message that the nurse really cared and valued their input into the day’s or night’s activities.

Schaffer P et al (2000)\textsuperscript{74} conducted a parents’ satisfaction survey whose children were admitted at a 250-bedded children’s hospital Medical Center, University of Cincinnati, USA. During 12 months period, 405 self-reported parent survey proformas were collected. In the survey, parents commented on caring, communication, safety, environment and appreciation practices of paediatric nurses. Parents’ satisfaction for different variable varied from 72 percent to 90 percent. Overall parents’ satisfaction was calculated to be 84 percent.

Andaleeb SS (2000)\textsuperscript{75} conducted a study to compare the quality of nursing services provided by public and private hospitals in Bangladesh. In paper it was hypothesized that private hospitals were not subsidized and depend on income from clients, they would be more motivated than public hospitals to provide quality of nursing services to patients to meet their needs more effectively and efficiently. This hypothesis was supported and concluded that patients in private hospitals were more
satisfied as compared to public hospitals. It was also added that demographic characteristics have a significant effect on patients’ satisfaction.

Uzun O (2001) conducted a patients’ satisfaction survey on 422 adults discharged from university hospital in Turkey. Findings revealed that their weighted scores in dimensions of nursing care were generally low, and there was statistically significant differences in means paired t-tests (p<0.01). Socio-demographic characteristics of the patients (age, gender, education level) in regard to patients’ satisfaction were determined. Several statistically significant differences were found between the socio-demographic characteristics and the weighted scores for dimensions of nursing care (p < 0.5). According to results, scores for five dimensions were negative to meet expectations. The negative scores for tangibles, reliability, responsiveness, assurance, and empathy indicate the areas needing improvement. In this hospital, results of this study support the need for nurses to take steps to improve patients’ satisfaction with nursing care.

Dana SN and Wambach KA (2003) conducted a study on patients’ satisfaction with an early discharge home visit program at University of Kansas Hospital Authority, Kansas City, USA. In this study after the child birth mothers and newborns were discharged early, a well planned home care follow-up program using an advanced nursing practices. Majority of the mothers i.e. 92 percent were highly satisfied with this approach and they liked nurses’ friendliness, technical skills, infant care teaching, and individualized care.

Niakas D et al (2004) investigated the patients’ satisfaction for the services provided by three public hospitals of Greece through a self-administered questionnaire from 1295 adult patients. The mean value of satisfaction for nursing services was 86.4 (maximum being 100). Hence, participants demonstrated high satisfaction rate for hospital services. Male patients, patient over 45 years of age and patient with lower education level showed higher level of satisfaction than their counterparts.

Merkouris Anastasios et al (2004) evaluated both qualitative and quantitative approach of the patients’ satisfaction with nursing care by interviewing 200 in-patients from two large Greek metropolitan hospitals. Findings revealed that as per quantitative data on an average, satisfaction ratings were moderate. Highest ratings were assigned to the technical aspects of care and to nurses’ response to patients’ demands whilst information delivery items were associated with the lowest rating.
Specifically participants were more satisfied with skillfulness, punctuality, continuity of care and were less satisfied with patient education and orientation which they received on admission. The interpersonal aspects of care and the availability of staff as well as the appropriateness of facilities were associated, on an average, with a moderate rating. In regard to specific items, participants rated respect and courtesy items higher than the items regarding concern/communication with staff and cleanliness of rooms and low satisfaction with cleanliness of toilets, noise levels and variety and temperature of meal. As per qualitative analysis of participants’ comments indicated, nurses were perceived as weak against organizational limitations. The patient commented on nurses as, responsive to patient’s needs, human and well-mannered but with exceptions, knowledgeable, expert technicians. The patients expressed the need for more nursing time spent on direct patient care. Further, the patients’ expression hinted at non-professional outlook of nurses, and closeness to nurses, but in the mean time they appreciated their closeness to patients and their family members. Hence, qualitative approaches provided objective and quantifiable indices, for evaluating care, which is necessary for comparison and monitoring and qualitative approach. The qualitative approach also unveiled the obvious and converts aspect of patients’ satisfaction as well as probable antecedents and causes.

A patients’ satisfaction survey was conducted by Egan M and Dowling M (2005)\textsuperscript{80} at Oncology Day Unit, Portiuncula Hospital, Ballinasloe, Ireland. This qualitative survey was conducted on 100 randomly selected patients by using an adapted version of the Leeds Satisfaction Questionnaire. Satisfaction levels were found to be favorable in general. However, the study did highlight that some aspects of patient information required attention where larger group of patients (67 percent) stated that they needed more information from nurses.

b) Patients’ satisfaction with health care services/ facilities

\textit{Indian literature}

Iyer A \textit{et al} (1996)\textsuperscript{81} carried out a pilot study on patients’ satisfaction among indoor patients of the Lokmany Tilak Municipal general hospital, Mumbai, in context of socio-economic background and basic hospital facilities. Data was collected from 123 indoor patients. They found that majority of the patients (71.4 percent) were from the city's slums or streets. The survey showed that 3.2 percent of patients were not provided with beds, 19.5 percent were not provided with linen and
16.3 percent were not given hospital clothing. Once provided, 21.1 percent of the linen and 27.6 percent of the hospital clothes had never been changed. Less than half of the respondents approved the hospital food. As against 19.5 percent who were provided with all the medicines by the hospital, a majority of the patients (68.1 percent), had to buy medicines from outside pharmacies. The situation vis-à-vis diagnostic facility was found to be better; nearly two out of three were able to get all the required diagnostic tests done at the hospital. One of the most startling findings of the survey was the fact that as many as 41.8 percent of the patients spent more on the daily expenses on hospital care, than their entire households earned in a day. The average monthly household income was rupees 2,749 per month, and patients spent an average of rupees 2,533 before and rupees 1,555 after admission. Regardless of all the problems they encounter at a public hospital, the study found that the overall patients’ satisfaction was high. They were impressed by the fact that it was a "big" hospital. In a touching display of faith, an astonishing 88.6 percent said that all doctors were competent, while 91.9 percent believed all nurses were competent. What explains these high levels of patient satisfaction? Only the poor come to public hospitals, many of them after getting exploited and neglected in the private hospitals. Besides, their daily living condition is several times worse than the conditions in the public hospitals. They are therefore grateful for whatever care comes in their way. Since they expect so little, so they fail to pressurize the institution to improve its standards.

Mahapatra P (2001) conducted a patient satisfaction survey in 25 district or area hospitals managed by the Andhra Pradesh Vaidya Vidhana Parishad (APVVP). The study obtained feedback from patients and, in case the patient could not be interviewed, the attendant, used a modified version of the Patient Satisfaction Questionnaire-III originally developed by Ware and others (Hays, Davies and Ware; 1987). The study was conducted during the period from May to July 1999. Altogether 1179 persons were interviewed, including 237 attendants, at the rate of about 40-50 patients per hospital. In each hospital, patients were selected by stratified random sampling. Stratification was on the basis of sex and wards. Most of the patients had already stayed for more than three days in the hospital and were drawn from all areas of hospital service including surgical, medical and maternity wards. Female and male patients of different ages are equitably represented in the sample. Majority of the patients were poor and illiterate. Study findings revealed that overall level of patients’ satisfaction in APVVP was about 65 percent of what could be achieved. Corruption
appears to be very highly prevalent and was the top cause of dissatisfaction among patients. Other important areas of hospital services contributing to patient dissatisfaction were poor utilities like water supply, fans, lights, etc., poor maintenance of toilets and lack of cleanliness, and poor interpersonal or communication skills.  

Bhattacharya A et al (2003) conducted a study on patients' satisfaction in a Tertiary Referral Hospital (PGIMER, Chandigarh). Study was conducted on attendants of 252 in-patients admitted in the wards and intensive care unit. Study findings revealed that 61 percent patients were paying for health care services. Fifty-nine percent of the attendants were literate. Overall level of satisfaction with doctors ranged from 89.3 percent to 99.6 percent. Very high levels of satisfaction were expressed on technical quality of doctors' work and their approachability. However 10.7 percent felt that doctors had not fully explained the disease and the treatment. The percentage of satisfied attendants regarding technical aspects of nursing care was above 90 percent. Literate attendants were more satisfied regarding approachability of nurses to their personal problems compared to illiterate/semiliterate attendants (P<0.01). However, the illiterates were more satisfied than the literate attendants with the advice given at the time of discharge by nurses (P<0.05). The level of satisfaction with behavior and attitude of nurses towards the attendants was poor, 24.2 percent attendants thought that some of the nurses were rude whereas 21.4 percent felt they were indifferent. In the Neonatal Surgical ICU (NSICU), a satisfaction level with attitude and mode of talking of nurses was higher with literate attendants. More than half of the attendants (62.5 percent) of NSICU found toilet facility adequate, while in wards 85 percent of attendants dissatisfied with this aspect. More than 94.5 percent of the attendants also responded positively to the general cleanliness and food. Authors concluded that although the unit under study provides satisfactory health care services in terms of technical quality, responsiveness, general cleanliness and food; certain areas need improvement namely communication, toilet facilities, facilities for attendants as well as attitude and behavior of paramedical staff. This improvement could be achieved by repeated monitoring of patients' satisfaction.

Waseem Qureshi (2005) conducted a patient satisfaction survey on 100 inpatients at SMHS hospitals, Srinagar. Findings of study revealed that 14.3 percent patients considered hospital services excellent, 69.9 percent considered hospital services good, 9.1 percent said that it was average and 6.7 percent of patients were
poorly satisfied with the hospital services. Highest satisfaction was found with attending doctors (50 percent), followed by quality of nursing care (31 percent), quality of laboratory work (13 percent). However, 32 percent patients were dissatisfied with linen supply, food items (22 percent), poor cleanliness of toilets and bathrooms (12 percent). In spite of that 95 percent were willing to recommend this hospital to their family and friends. Most of the patients suggested that medicines and surgical items should be made available in hospitals, even they have to pay for that.81

A study was conducted (2007)85 on patients’ satisfaction in district, sub division and rural hospitals of state West Bengal under State Health System Development Project, where it was found that 84 percent indoor patients and 83 percent out door patients were satisfied. Furthermore, it was added that satisfaction to various other indoor factors were: nursing care (30 percent), doctors’ attention (26 percent), overall cleanliness (15 percent), others attitude (15 percent), medical care in time (13 percent), and availability of diagnostic tests (1 percent).

Western Literature

A study was conducted by Carmel S (1985)86 to explore whether and to what extent patients' satisfaction with three types of hospital services (medical, nursing and supportive) is differentially explained by patient's socio-demographic, psychosocial, situational and attitudinal characteristics. To achieve this, 476 patients were interviewed. The results of the analysis of their general satisfaction with hospitalization and a comparative analysis of satisfaction with the three types of services were presented. The best predictors of satisfaction with all three types of services (in order of their importance) were found to be: perceived improvement in health, size of social networks, satisfaction with organizations in the past, and age. The type of ward (medical vs. surgical) was found to be a powerful predictor of satisfaction with physicians and nurses only. Ward effect was also interactive improvement in one's health predicts significantly more satisfaction with medical services in medical wards than in surgical wards. The findings of this study suggested that when clients perceive that their main goal has been achieved (i.e. improvement in health), they tend to attach little importance to deficiencies in the process of achieving it (i.e. the provision of services).

Seguin L et al (1989)87 conducted a study on 1790 women who received maternity care, in order to get better understanding of women’s satisfaction with
maternity care. Participation in the decision-making process was the first component of satisfaction with medical care. Information received, appeared to be the major component of their satisfaction with nursing care. The physical environment did not affect women's satisfaction with obstetric care.

Surveys of patients' satisfaction done by Ray Fitzpatrick (1991)\textsuperscript{88} identified different dimensions of patients' satisfaction with health care like humanness, informativeness, overall quality, competence, bureaucracy, access, facilities, continuity and attention to psychosocial problems.

Hall MC \textit{et al} (1993)\textsuperscript{89} carried out a study to evaluate the correlates, dimensionality, and determinants of patients' satisfaction in the hospital health care. The findings suggested that patients evaluated hospital service quality along with four distinct dimensions. The relative importance of these four factors in predicting overall satisfaction, in descending order, was: (1) physician/capabilities, (2) nurses/staff, (3) amenities, and (4) accessibility. In combination, these four factors explained 63 percent of overall patients' satisfaction.

Bruster Stephen \textit{et al} (1994)\textsuperscript{90} interviewed 150 randomly chosen patients, for patients' satisfaction survey from 36 NHS hospitals in England who had been discharged, recently. Results showed that all the questions except those related to food items showed 89 per cent satisfaction rating. But some problems were also highlighted in the survey, particularly regarding communication, pain management, discharge planning and untold warning signs. The hospital failed to reach the standard of patient charter, for example in explaining the treatment proposed, giving patient the opinion of not taking part in students' training, not caring about privacy of the patients.

Charles C \textit{et al} (1994)\textsuperscript{91} conducted a survey on adult medical and surgical patients about their concerns and satisfaction with their care in public Canadian hospitals. The main measurements included satisfaction with (a) provider-patient communication (including information given), (b) provider's respect for patient's preferences, (c) attentiveness to patient's physical care needs, (d) education of patient regarding medication and tests, (e) quality of relationship between patient and physician incharge, (f) education of and communication with patient's family regarding care, (g) pain management and (h) hospital discharge planning. Results of the study showed that most (61 percent) of the patients reported problems with 5 or fewer of the 39 specific care processes asked about in the study. Forty-one percent of
the patients reported that they had not been told about the daily hospital routines. About 20 percent of the patients receiving medications reported that they had not been told about important side effects in a way they could understand; 20 percent of the patients who underwent tests reported similar problems with communication of the test results. Thirty-six percent of those having tests had not been told about how much pain they may expect. In discharge planning, the patients complained that they had not been told what danger signals to watch for at home (reported by 39 percent), when they could resume normal activities (32 percent) and what activities they could or could not do at home (29 percent). Over 90 percent of the patients reported that they had a relationship of confidence and trust with their physician and that they had been involved in decision making as much as they wanted to be. Fifteen percent of the patients whose admissions had been scheduled, felt that they should have been admitted sooner.

Larson CO et al (1996) conducted a non-experimental study on 167 acute Myocardial Infarction patients at USA to determine an association between meeting patients' information needs and their overall satisfaction with care and their general health status outcomes. The independent variable was an index measuring how well patients' information needs were met. The dependent variables were patients’ satisfaction (ratings of satisfaction with care process, global satisfaction, and health benefit) and general health status outcomes (physical function, psychosocial function and quality of life). The multivariate regression results showed that meeting the information needs were positively and significantly associated with both patients’ satisfaction measures (i.e., ratings of care processes, p < 0.01; global satisfaction, p<0.05, perceived health benefit, p < 0.01) and one general health status measure (i.e. quality of life, p < 0.01). The results suggested that providers of care should ensure that they meet the information needs of patients with specific conditions because patients' perceptions of both quality of care and quality of life are associated with the clinicians' ability to transfer key information to their patients.

Tengilimoglu D et al (1999) carried out a study on 2,045 patients discharged from seven major public and private hospitals in the Turkey. Data were collected about patients’ satisfaction regarding several ancillary hospital services. Study findings revealed that higher number of patients were satisfied in private hospitals as compared to public hospitals about selected facilities (e.g., comfort, cleanliness, parking). This difference was found statistically significant (p <0.05).
Gotlieb JB (2000) conducted a study to identify specific hospital variables that affect the perceived quality of care. This article presented a proposed model and empirical evidence that was based upon this general framework. Findings revealed that the physical environment (i.e., patients' perception of their hospital rooms) and people (i.e., patients' perception of nurses) affected patients' perception of hospital quality. The process (i.e., patients' perception of control over the process) did not directly affect their perception of hospital quality. However, patients' perception of control over the process and their perception of hospital rooms affected their perception for nurses. Consequently, this research suggested that the general framework identified by service marketing researchers could be applied to understand how patients develop their perception of hospital quality. He furthermore, concluded that, service marketing researchers suggested that the physical environment, the people, and the process strongly affect consumers' judgments when they evaluate services.

Tengilimoglu D et al (2001) measured the patients' satisfaction by administering a questionnaire verbally to 420 adults discharged from a major hospital of Turkey. Results demonstrated that 85 per cent of patients were satisfied with the services provided by nurses. The patients who were graduates were less satisfied than patients with lower level of education. More than half of the respondents felt that food services, communication system of hospital, room comfort and equipment availability were poor or insufficient or both and another 48 percent reported that general cleaning services in hospital were poor.

Swan JE et al (2003) conducted a study to identify the effects of appealing hospital rooms on patients evaluation of hospital services. This field study revealed that out of contrasting, appealing and typical rooms; appealing rooms resulted in more positive patient evaluations of physicians and nurses, as well as more favorable patients' judgment of the services.

A study was conducted by Maisels MJ and Kring EA (2005) in William Beaumont Hospital, Royal Oak, USA. Study was carried out to assess whether improved communication with families may significantly increase their satisfaction with the care of their hospitalized child. In this study, the families of children admitted to a general pediatric services were randomly assigned to receive a daily visit from a communicator/facilitator whose purpose was to respond to any questions the family might have and, if necessary, to explain results of laboratory tests. Control
families received routine care. At the time of discharge, families were asked to complete a brief questionnaire regarding the quality of nursing and medical care. There was a highly significant improvement in parents’ satisfaction with nursing and medical care due to improved communication (p<0.005). Furthermore, they stated that many of which were unrelated to the medical problem at hand, had a salutary effect on overall patient and family satisfaction with both nursing and medical care.

A patient satisfaction survey (2005) reported that patients were found highly satisfied with their inpatient stay. About 89 percent patients were overall satisfied, 90 percent said that they will recommend others for this hospital, 88 percent felt that care/ treatment was well coordinated. 91 percent patients said that hospital helped us to achieve our health goals. As per patients satisfaction toward specific services, highest patient satisfaction was for physical therapies i.e. 93 percent, followed by occupational therapy (92 percent), medical services (91 percent), admission process (90 percent), nursing services (87 percent), communication (86 percent), social work services (85 percent), and therapeutic recreation (84 percent).

Taner T and Antony J (2006) conducted a study with aim to examine the differences in service quality in form of patients’ satisfaction between public and private hospitals in Turkey. The study was conducted on 200 patients. The results indicated that inpatients in the private hospitals were more satisfied with service quality than those in the public hospitals. The results also suggested that inpatients in the private hospitals were more satisfied with doctors, nurses and supportive services than their counterparts in the public hospitals. Finally, the results showed that satisfaction with doctors and reasonable costs was the biggest determinant of service quality in the public hospitals.

Haase I et al (2006) concluded that in order to increase patients’ satisfaction in hospitals one should aim for not only high quality in medical care, but also for the creation of a pleasant atmosphere.

c) Determinants of patients’ satisfaction

There are various factors that affect patients’ satisfaction with nursing care and healthcare. The major eight domains that have an influence on patient satisfaction with nursing care: the socio-demographic background of the patients, hospital characteristics, morale of health care professionals, patients' expectations, the physical environment, communication and information, participation and involvement,
interpersonal relations with patients, medical-technical competence of health care professionals, and the influence of the health care organization on both patients and employees (Johansson P et al, 2002).

i) Socio-demographic characteristics

Van Servellen G (1991) conducted a study to assess patients' satisfaction with nursing care in seven hospitals. Five of the hospitals utilized the special care unit (SCU) method of delivering care to AIDS or oncology patients; three had SCUs for AIDS patients. All of the seven hospitals had integrated units (IUs) where general medical, oncology, and/or AIDS patients were received in various proportions. Satisfaction with nursing care was measured with the Risser Patient Satisfaction Instrument. Patients' satisfaction with nursing care was shown to be a function of delivery method; AIDS and oncology patients on SCUs expressed greater satisfaction with their care than medical, oncology, or AIDS patients on IUs (p < 0.001). Patient satisfaction with nursing care was greater among whites than nonwhites. There were also some major socio-demographic and case mix variables, such as age, employment status, and diagnosis, which were not associated with patients' satisfaction directly.

Guirguis WW et al (1992) conducted a descriptive study to identify the determinants of the overall patients' satisfaction towards hospital services. It was found that out of 12 patient characteristics, age was the most important determinant of overall satisfaction, followed by gender. Perceived health status, clinical department, and expectations about the quality of services before admission were also significant but less important determinants of overall satisfaction. Marital status, level of education, nationality, and previous hospitalization in the study hospital, in Kuwait, or in a western country hospital, all had no significant effect on overall satisfaction. Concerning the effect of satisfaction with specific dimensions of hospital services on overall satisfaction, it was found that satisfaction with physicians was the most important determinant of overall satisfaction, followed by satisfaction with housekeeping and with nurses. Satisfaction with hospital environment, facilities and with admission process were also significant but less important determinants of overall satisfaction, while satisfaction with food and radiology services did not affect overall satisfaction. The level of overall satisfaction as well as satisfaction with specific dimensions of hospital services were quite high. Physicians' care was the most favorably rated dimension, followed by admission process and housekeeping,
while nursing care was the least favorably rated dimension. Among the attributes of physicians' and nurses' care, technical care and courtesy were the most favorably rated items; while communication, particularly imparting of information, was the least favorably rated aspect. Several attributes of the hospital environment, facilities and of the food services were found to be dissatisfying to the patients.

Wood DL (1993)\textsuperscript{104} carried out a comparative study on poor and non-poor family satisfaction consisting representative 2199 subjects. Finding depicted that the majority of parents were satisfied with many aspects of their interactions with physicians. However, poor families were more likely to be not completely satisfied with the medical care their children received at their last health visit than non-poor families (27 percent vs. 12 percent, $P < .001$). With regard to specific aspects of the physician-patient communication, poor families were more likely to be not satisfied with the physician's provision of information about the illness (40 percent vs. 21 percent, $P > .001$); the physician's discussion of examination findings (21 percent vs. 9 percent, $P < .001$); and the opportunity provided by the physician to express their concerns (12 percent vs. 6 percent, $P < .001$). Logistic regression demonstrated that poor patients were approximately twice as likely to be not satisfied with the medical encounter and with various aspects of their communication with the physician. It was concluded that the parents of poor children were less satisfied with care.

Khayat K and Salter B (1994)\textsuperscript{105} undertook a study on 2173 adult patients to investigate role of socio-demographic characteristics in patients' satisfaction. Results revealed that younger patients were less satisfied than older patients. Women, those in social classes 1-3N, home owners and those who left school (17 years or older) were more critical of primary care services than men, those in social classes 3M-5, tenants and those who left school before the age of 17 years.

Rosenheck R \textit{et al} (1997)\textsuperscript{106} conducted a study on 13574 patients to examine patient and facility-related determinants of satisfaction with inpatient mental health services. Findings of the study revealed that the strongest and most consistent predictors of satisfaction were older age and better self-reported health. Longer length of stay was also associated with greater satisfaction on a majority of subscales. Findings among female and minority veterans were mixed across measures. Large facilities and facilities that specialize in mental health treatment had lower levels of satisfaction than others. Patient characteristics accounted for more of the variance in
satisfaction than did facility characteristics. It was concluded that older and healthier patients reported greater satisfaction with mental health care services.

Young GJ et al (2000)\textsuperscript{107} carried out a study on effects of demographic and institutional characteristics on patient’s satisfaction. Findings revealed, among demographic characteristics; age, health status, and race consistently had a statistically significant effect on satisfaction scores. Among the institutional characteristics, hospital size consistently had a significant effect on patients’ satisfaction scores.

Donaghy et al (2000)\textsuperscript{108} conducted a study on the role of patient characteristics in pregnant women's satisfaction with nursing care. They considered that most important for satisfaction was being well educated, having a less anxious mood at 29 to 34 weeks' gestation, age, large friendship networks, and strong community ties. Study findings concluded that satisfaction is highly related to communication. The less educated, those experiencing more anxious mood prior to delivery, and those feeling less connected to others required more information and emotional support in order to facilitate accurate communication and high patients’ satisfaction.

Da Costa D et al (2001)\textsuperscript{109} conducted a study to examine the effect of physical and mental health status and social support on patients’ satisfaction with health care in patients with systemic lupus erythematosus (SLE). The findings revealed that self-reported physical and mental health status and social support were more important than clinical status variables in understanding patients’ satisfaction with medical care.\textsuperscript{106}

Nguyen Thi PL et al (2002)\textsuperscript{110} conducted a study on 533 patients to identify factors associated with satisfaction among inpatients receiving medical and surgical care for cardiovascular, respiratory, urinary and locomotor system diseases. Findings illustrated that the two strongest predictors of satisfaction for all dimensions were older age and better self-perceived health status at admission. Men tended to be more satisfied than women. Other predictors specific for certain dimensions of satisfaction were: married, Karnofsky index more than 70, critical/serious self-reported condition at admission, emergency admission, choice of hospital by her/himself, stay in a medical service, stay in a private room, length of stay less than one week, stay in a service with a mean length of stay longer than one week.

Effect of gender of patients’ satisfaction was studied by Foss C (2002)\textsuperscript{111} using data from a Norwegian survey of patients’ satisfaction. The survey included 1469
male and 1226 female patients. Results showed that young female patients were less satisfied with all aspects of nursing care when compared with young male patients. Female patients experienced, quite contrary to their male counterparts that the nursing staff was less committed and caring, had less time and was less skilled. The young women were also less content with what they felt was a lack of opportunity to provide the staff with information they believed to be important to their condition or ailment. Analysis also revealed that female patients, compared with their male counterparts, indicated a higher score on the subjective importance of the different aspects of care.

Jenkinson C et al (2002)\textsuperscript{12} conducted inpatients study at Scotland to determine what aspects were most likely to influence satisfaction with care. Study results had shown that almost 90 percent of respondents indicated that they were satisfied with their period of inpatient care. Age and overall self-assessed health were only weakly associated with satisfaction. A multiple linear regression indicated that the major determinants of patients’ satisfaction were physical comfort, emotional support, and respect for patient preferences. However, many patients who reported their satisfaction with the care they received also indicated problems with their inpatient care as measured on the Picker Inpatient Survey; 55 percent of respondents who rated their inpatient episode as "excellent" indicated problems on 10 percent of the issues measured on the Picker questionnaire.

Jenkinson C et al (2003)\textsuperscript{13} in their study concluded that patients' experience should not be used to rank providers, although detailed information from patient surveys had a useful role in determining priorities for quality improvement within individual hospitals and for assessing changes over time.

Patients’ satisfaction has become an important indicator to measure the quality of care. Nursing has long used outcome measures to evaluate health care. Han CH et al (2003)\textsuperscript{14} conducted a study to assess the patients’ satisfaction from medical and surgical units at a teaching hospital of southern Taiwan. The total mean satisfaction score for all the patients was 4.28±0.53. In general it reflected that the patients were satisfied. There was no significant difference between the patient demographic variables, primary nurse's age, marriage, and total working experience on any of the subscales. Results of this study provided evidence that primary nurse's unit working experience can influence patients’ satisfaction (P<.05).
Bahramoour A and Zolala F (2003) conducted a study to determine the level of patients' satisfaction in hospitals in Kerman and to determine the factors affecting satisfaction. Investigators carried out an analytic cross-sectional study on 3017 patients. Findings of study revealed that just fewer than 50 percent of patients were satisfied. There was a significant relationship between satisfaction and type of hospital (P < 0.001), ward (P < 0.006), education level (P < 0.004), history of hospitalization (P < 0.001), need for medical services (P < 0.001), health status (P < 0.001) and duration of hospitalization (P < 0.002).

Jaipaul CK and Rosenthal GE (2003) conducted a study to determine relationships between age, self-reported health, and satisfaction in a large cohort of hospitalized patients. This cross-sectional survey was conducted on 64,900 randomly selected medical surgical patients. Patients' overall ratings of hospital quality and satisfaction with 5 aspects of care (physician care, nursing care, information provided, discharge instructions, and coordination of care) were measured by a validated survey, which was mailed to patients after discharge. Analyses compared satisfaction in 5 age groups (18 to 35, 36 to 50, 51 to 65, 66 to 80, and > 80 years). Scores for the 5 aspects of care initially increased with age (P <.001) and then declined (P <.001). A similar relationship was found in analyses of the proportion of patients who rated overall quality as "excellent" or "very good." Satisfaction was also higher in patients with better self-reported health (P <.001). In analyses of patients with poor to fair health, satisfaction scores peaked at age 65 before declining. However, for patients with good to excellent health, scores peaked at age 80. Moreover, declines in satisfaction in older patients were lower in patients with better health. Finally, they concluded that satisfaction exhibits a complex relationship with age, with scores increasing until age 65 to 80 and then declining. This relationship was consistent across individual satisfaction scales, but was modified by health status. The results suggested that age and health status should be taken into account when interpreting patients' satisfaction data.

Al-Doghaither AH (2004) conducted a patients' satisfaction survey on 400 inpatients with physician services at King Khalid University Hospital, Riyadh. The highest mean satisfaction score was for admission and the lowest for communication. Among service items, the highest mean score was for physicians enquiring about patient conditions and opinions when planning care and the lowest for physicians
asking for opinions about the care quality and problems. Female and less educated patients were more satisfied with their care than male and educated patients. Male surgical and medical ward patients were most dissatisfied with physicians' services.

González-Valentin A (2005) evaluated the satisfaction of patients with nursing care in a regional university hospital in Southern Spain. Findings showed that the only factors significantly associated with lower patients' satisfaction were female gender, higher educational level, lower overall satisfaction with the hospital, and not knowing the name of the nurse.

Sahin B et al (2006) conducted a study to determine the factors affecting general satisfaction level of patients with the food services in a military hospital in Turkey. The results showed that 51.3 percent patients evaluated food service quality as adequate, 32.4 percent said that the food quality was inadequate, and 16.3 percent stated that they were uncertain. Patient-specific demographic characteristics were insignificant in explaining satisfaction level with food services, but the variables of taste (OR = 9.853, p = 0.000) and appearance (OR = 2.687, p = 0.014) of the food were statistically significant and important determinants of patients' satisfaction with the foods were served at the hospital.

Vastardi M (2006) in his study concluded that the higher income scale patients were least satisfied than the lower income scale patients. Liu Y and Wang G (2007) conducted a study to examine inpatient satisfaction with nursing care in a teaching hospital in China. Patients' satisfaction with nursing care was assessed by a self-designed questionnaire administered to 320 inpatients selected by a convenient sampling method. The patients had a relatively high level of satisfaction with nursing care. Patients' age, educational background, occupation, methods of payment, and hospital wards were the main factors influencing their satisfaction with nursing care.

**ii) Patients’ satisfaction in public vs. private hospitals**

Fleming GV (1981) conducted a study to examine the relationship between hospital structural characteristics and patients’ satisfaction with hospital care. Teaching hospitals and private hospitals were expected to receive higher ratings of patients’ satisfaction than were non-teaching and government-controlled hospitals, because generally they are reputed to be technologically superior. Results have shown that, in general, most of the patients were satisfied with their hospital stays, but
clearly they were more dissatisfied with their stays in teaching hospitals. Although a number of other correlates of patients’ satisfaction with the hospital stay were identified, no measures succeeded in reducing to insignificance the strong relationship between teaching status and dissatisfaction.

Ikegami N and Kawakita H (1987) conducted a cross-sectional study of 119 hospitals in Japan to find out which factors were related to patients’ satisfaction. Study findings revealed that the patient's overall satisfaction was found to be a reliable and valid evaluation for hospital performance and was unrelated to patients’ characteristics or hospital size, ownership and location. To improve patients’ satisfaction, it seemed that there was a need to improve not only the nursing level, but also to well inform employees, to have a clear management policy, to have a good labour-management relationship and to initiate the newly employed.

Tangcharoensathien V et al (1999) conducted a study to compare patient perceptions of quality of inpatient and outpatient care in hospitals of different ownership and to explore how patient payment status affected patient perception for quality. Inpatient and outpatient satisfaction surveys were implemented in nine purposively selected hospitals: three public, three private for-profit and three private non-profit. Results of the study have showed that clear and significant differences emerged in patients’ satisfaction between groups of hospitals with different ownership. Non-profit hospitals were most highly rated for both inpatient and outpatient care. For inpatient care public hospitals had higher levels of satisfaction amongst clientele than private for-profit hospitals. For example 76 percent of inpatients at public hospitals said they would recommend the facility to others compared with 59 percent of inpatients at private for-profit hospitals. This pattern was reversed for outpatient care, where public hospitals received lower ratings than private for-profit ones. Patients under the Social Security Scheme, who are paid for on a capitation basis, consistently gave lower ratings to certain aspects of outpatient care than other patients. For inpatient care, patterns by payment status were inconsistent and insignificant.

Lech MM and Petryka I (2002) conducted a study to evaluate patients’ satisfaction in relation to private or public health care provider in the Warsaw's (capital of Poland). Total 590 adult patients were randomly studied from 20 private and public owned clinics and hospitals. Study findings revealed that patients of
private owned clinics (but working on contract with general health insurance system) are much more satisfied from the services provided by these clinics than patients treated by local government-owned clinics. In general patients treated in hospitals were more satisfied than patients treated in clinics. Comparison of more detailed determinants of satisfaction have shown that all health service facilities in study region, in their practices do not consider the "concentration on real needs of patients" as a serious matter and this is the reason of patients' dissatisfaction. Level of satisfaction from the services provided by health care facilities did not correlate with gender or age of the respondents. In opposite, the (higher) level of education and place of living (in a big city) had negatively correlated with patients' satisfaction.

McCluskey PJ (2007)\textsuperscript{126} carried out a cross-sectional survey to assess the effect of hospital size and teaching status on patient experiences with hospital care in Norway. Study findings revealed that patients admitted in small hospitals reported higher satisfaction score as compared to patients admitted in large teaching hospitals. However, it was concluded that the effect of hospital category on patients' satisfaction with hospital care was small. Therefore, hospital category was not a major determinant of patient experiences during hospitalization.

1.11 Inferences of Literature Review

Patients’ satisfaction was considered as an evaluation tool for nursing care in many of the studies. In most of the studies patients have shown moderate to high level of satisfaction. The satisfying factors were skills, attitude and professionalism of nurses, patient nurse relationship and coordination among team members etc. In the meantime certain aspects with which patients were not satisfied, were also highlighted in the literature; these being education during discharge, nurse’s behaviour, communication system of hospital, food, cleanliness of hospital etc. Patients valued those nurses, who were dedicated, efficient and professional in their conduct. Further, a few studies emphasized on the comparison of nurses and patients’ perception of patient care and stressors for patient. Suggestions meant given for improving nursing care as to satisfy the patients have also been discussed in literature.

There were certain studies about determinants of patients’ satisfaction. It was found that there are various factors which affect the patients’ satisfaction, like their socio-demographic characteristics, self perceived health status, anxiety, pain, previous
experience with health care facility, cost of care, duration of hospitalization, social support, patients’ expectations, type of illness etc. however, there was inconsistency in results of the different studies regarding relationship of above said factors with patients’ satisfaction.

There were few studies on patients’ satisfaction with ward facilities or room facilities. Most of these studies focused on patients’ satisfaction with cleanliness of the wards, toilets and bathrooms and food supply, which were the main dissatisfying factors in Indian scenario as compared to western world.

The literature was extensively searched to study maximum available instruments to measure satisfaction. Most critics have argued that patients’ satisfaction ratings were generally high. This has been attributed to several factors such as, individuals are unaware of the inadequacies of care that they are more comfortable in reporting their positive response, or if they are not satisfied they seek medical help elsewhere. Also it is affected by attitude of the patients and past experiences with medical care.

1.12 Need/ Scope of Present Study

Patients’ satisfaction with nursing care and ward facilities are the major predictors of patients’ overall satisfaction with health care facility. In the light of “Consumer Protection Act” assessment of patients’ satisfaction is an important aspect. Therefore, it is important to assess what the patient perceives and thinks about nursing care. Moreover, there is a limited data available in literature regarding patients’ satisfaction with nursing care.

Extensive literature review found that there was large amount of literature available about patients’ satisfaction and factors affecting patients’ satisfaction. However, there were only few studies available regarding patients’ satisfaction with nursing care. Moreover, an extensive review of the Indian literature indicated that studies available on patients’ satisfaction with nursing care pertaining to our own scenario were restricted in number. These Indian studies were conducted with very small sample varying between 50 to 150. Moreover, majority of Indian studies were not conducted on general unit patients, rather these were conducted on specific patient population like postnatal mothers’ satisfaction or parents’ satisfaction with nursing care of their hospitalized children or studies devoted to patients’ and relatives’ views
to measure patients’ satisfaction. Surprisingly, not even a single study was conducted in India regarding patients’ satisfaction with ward facilities. Therefore, present study titled “Nursing Care Administration: A study of patients’ satisfaction in selected government and private hospitals” was planned to assess nursing care administration and patients’ satisfaction with ward facilities and nursing care.

Present study interviewed 1200 hospitalized patients only in age group of 18 onwards from general wards/units (General Medicine, General surgery, orthopedics, and maternity). This study was conducted on four hospitals of Ludhiana; that is two private hospitals (Christian Medical College and Hospital and Dayanand Medical College and Hospital), and two government hospitals (Civil Hospital and ESI Hospital), Ludhiana, where different selected variables were studied: (1) Nursing administration of selected hospitals, (2) Ward management in selected hospitals (comparative study of general wards in selected hospital), (3) patients’ satisfaction with selected ward facilities/services, (4) Patients’ satisfaction with nursing care. 5) Effect of patients’ socio-demographic characteristics and other selected variables on their satisfaction were also studied.

Since the study comprised of a large sample and a comparative study of public and private hospitals, so an extensive literature search was done with a view to develop an effective, standardized, valid patients’ satisfaction measurement tool. Furthermore, a one to one interview technique between patient and investigator helped to eliminate individualized errors. Therefore, it was expected to generate more valid data, where findings could be generalized. Findings of this study in the real sense would present criticism as well as views of patients regarding nursing care, ward facilities/services and indirectly nursing care administration. Nursing administrators may absorb, introspect and correct the flaws with the help of this study. In a way, the present study is a modest attempt to provide scientific basis for nursing administrators to plan improved measures for achieving better patients’ satisfaction results. Nevertheless this study would provide baseline data for future research work on similar issues.

1.13: Description of selected hospitals

The four hospitals selected for study; two of them were private teaching hospital (Christian Medical College & Hospital, Dayanand Medical College &
Hospital, Ludhiana) and other two were government hospitals (Civil Hospital, and Employees' State Insurance Corporation Hospital, Ludhiana). All these four selected hospitals have peculiar characteristic of origin and authority viz. DMC hospital is a private teaching hospital, CMC hospital is a missionary teaching hospital, Civil hospital is a state run public hospital and ESI hospital is an autonomous Employees’ State Insurance Corporation New Delhi (Central Government) controlled hospital.

**a) Christian Medical College and Hospital** is one of the oldest medical institutions of Asia. It is a college of distinction with a rich tradition of exemplary work. A trend setting team of dedicated faculty, backed by quality infrastructure and research facilities, provides ideal learning ground for medical, dental, nursing and paramedical students in the heart of Punjab. CMC hospital, Ludhiana has been ranked 14th amongst the best medical colleges of India by a recent survey conducted by the India Today. In fact, over the years this institution has been ranked among the top twenty medical colleges under various surveys and studies. The vision of this college is to contribute to the real health needs of India by training young Christian men and women as competent, committed and compassionate health workers along with young men and women of other faiths and communities who identify themselves with the goals and spirit of serving of the institution.

It all started when Ludhiana was selected for the establishment of the North India School of Medicine for Christian women on 20th December 1893 by fourteen people, under the initiative of Dr. Edith Brown, in a rented building. But soon their work grew in stature and good will and was moved into a thirty bedded hospital loaned by a Scottish which opened with just four students, who grew and provided life saving services during calamities like the plague epidemic of 1901 – 1902, Kangra earthquake and Quetta earthquake. Another milestone happened when the institution threw open its doors for men as well as women and then upgraded to MBBS level, acquiring the necessary infrastructure to be recognized by the Punjab University.

CMC hospital continued its services, soothing the wounds during the Partition blood shed, the militancy days, the Gujarat earthquake, the Tsunami in Tamilnadu and the recent earthquake in Kashmir, Uttaranchal and Haryana from time to time.
The postgraduate courses were started in the college in the sixties and today practically all departments are recognized for postgraduate training. Super specialties were started in the seventies and are recognized for postdoctoral degrees. M.Ch. (plastic surgery), DM (cardiology). Ph.D. anatomy and many more super specialty departments are in the process of seeking reorganization for postdoctoral degrees. Today teaching institutes are supported with 663 bedded multi specialty tertiary care hospital. Hospital is providing patient care, medical education, dental education, nursing education and many more paramedical courses. In addition this hospital is known for its community out reach services.

Institution has following manpower to render health services:

- Medical personnel : 391
- Dental personnel : 26
- Nursing personnel : 578
- Paramedical personnel : 253
- Ministerial staff : 577
- Ancillary staff : 430

This hospital is well equipped with advanced emergency and critical care instruments, which includes 32 invasive ventilators, eight defibrillators, more than 15 pulse oxymeters, 64 cardiopulmonary monitors, 04 intermittent pneumatic pressure machines and 5 well equipped resuscitation trolleys.

Hospital has separate central sterile supply department, pharmacy (5), laundry with machine drier, medical record section, main store, mortuary, waste management plant, canteen on each floor, facilities for stay of relatives, library, reception, public relation office, dietary department, hospital transport facilities, spiritual and religious facilities. In addition, hospital has crèche for children of staff. Hospital corridors and wards had flat TVs for recreational facilities for patients and their relatives. This is a missionary private teaching hospital, which manages its budget with a revenue generated from patient fee and certain grants from various national and international missionary organizations. Presently OPD charges for the new patients are Rs.30 and Rs.20 are charged on each subsequent visit. The hospital has also setup private OPD where visiting charges per patient are Rs.200. The admission fee for general and
private wards is Rs.350 and Rs.500 respectively. Daily bed charges are Rs.100 for
general ward and Rs.950-1650 for private ward.

Table 1.4: Performance indicators of the CMC hospital during last five years

<table>
<thead>
<tr>
<th>Performance Indicators (Number of patients)</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPDs New</td>
<td>62494</td>
</tr>
<tr>
<td>Revisit</td>
<td>257070</td>
</tr>
<tr>
<td>IPDs (admissions)</td>
<td>19872</td>
</tr>
<tr>
<td>Deliveries</td>
<td>1372</td>
</tr>
<tr>
<td>Minor operations</td>
<td>3102</td>
</tr>
<tr>
<td>Major operations</td>
<td>6297</td>
</tr>
<tr>
<td>Average bed occupancy</td>
<td>368</td>
</tr>
<tr>
<td>Deaths</td>
<td>1212</td>
</tr>
</tbody>
</table>

Source: official documents of Medical Record Section

b) Dayanand Medical College and Hospital was setup with devoted efforts of Dr. Banarsi Dass Soni, Ex Captain I.M.S. with a missionary zeal for medical education and patient care. He conceived the idea of starting a Medical School for training doctors and providing much needed medical care to the people. This noble idea bloomed in the form of Arya Medical School in the year 1934. Initially it was started with only 20 students in a rented building in the civil lines, Ludhiana. In 1936, its management was handed over Arya Pratinidhi Sabha, Punjab, to be managed by the managing Committee of Arya High School, Ludhiana. In 1937 it shifted to its own building, which is known as Old DMC campus.

Initially, the medical school was authorized for providing LSMF (Diploma of the Punjab State Medical Faculty) besides running a hospital attached to it. In the following year i.e. 1939 Ludhiana Medical School was renamed as 'Arya Medical School and Hospital.

In the year 1964 inconsonance with the policy of the state Government; the Arya Medical School flowered into a full-fledged MBBS college, and was rechristened as Dayanand Medical College and Hospital. Consequently a new managing committee comprising of certain prominent people from different walls of
life was set up known as the ‘Managing Society of Dayanand Medical College and Hospital, Ludhiana. Later H.R. Dhanda, a prominent industrialist of the town, became its founder president.

At present Dayanand Medical College and Hospital (DMCH), Ludhiana is 1036 bedded hospital with general and super-speciality medical services. Hospital is rendering patient care; medical education (MBBS, MD/MS and DM/ M.Ch), nursing education (GNM, B.Sc. Nursing, Post basic B. Sc. Nursing) and community/ out reach services to community.

This institute has following manpower to render health care services:

- Medical personnel : 354  Nursing personnel : 697
- Paramedical personnel : 202  Ministerial staff : 114
- Ancillary staff : 431

Table 1.5: Performance indicators of DMC hospital during last five years

<table>
<thead>
<tr>
<th>Performance Indicators (Number of patients)</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPDs</td>
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</tr>
<tr>
<td>IPDs (admissions)</td>
<td>33180</td>
</tr>
<tr>
<td>Deliveries</td>
<td>582</td>
</tr>
<tr>
<td>Minor operations</td>
<td>4006</td>
</tr>
<tr>
<td>Major operations</td>
<td>2674</td>
</tr>
<tr>
<td>Average bed occupancy</td>
<td>428.99</td>
</tr>
<tr>
<td>Deaths</td>
<td>1505</td>
</tr>
<tr>
<td>LAMA</td>
<td>1117</td>
</tr>
</tbody>
</table>

*Source: official documents of Medical Record Section*

Hospital is running medicine, cardiology, nephrology, endocrinology, neurology, chest, oncology, paediatrics, dentistry, dermatology, psychiatric, surgery, plastic surgery, paediatric surgery, oncology surgery, neurosurgery, gastroenterology, urology, orthopaedics, eye, obstetric & gynecology, postpartum and family planning out patient department services for six days a week from Monday to Saturday.
This hospital is well equipped with advanced emergency and critical care instruments, which includes 72 invasive ventilators, 30 defibrillators, more than 60 pulse oxymeters, 142 cardiopulmonary monitors, 20 intermittent pneumatic pressure machines and 25 well equipped resuscitation trolleys. Hospital has separate central sterile supply department, pharmacy on each floor, laundry with machine drier, medical record section, main store, mortuary, waste management plant, canteen on each floor, facilities for stay of relatives, library, reception, public relation office and hospital transport facilities with 5 buses, 2 ambulances and 5 staff car. However institute is deficit with crèche, religious or spiritual services.

This is a private hospital, which manages its budget with revenue generated from patient’s fee. The OPD charges are Rs.30 and Rs.250 for private OPD. The patients are required to deposit rupees 2000 in advance for admission.

c) Employees’ State Insurance Hospital was commissioned in 1968 with 100-bedded super-specialty hospital, under state Government authority. That time, it was known as ESI hospital, Ludhiana. To ensure proper secondary care facilities for ESI beneficiaries, the Employees’ State Insurance Corporation (ESIC) decided to setup one best secondary providing hospital in each state. Out of all existing ESI hospitals, in Punjab state, ESI hospital Ludhiana was identified to provide all modern infrastructure facilities, staff and equipments as per ESI norms and to act as referral hospital for the entire state to provide secondary level care services. From 1st November 2001 it was taken over by ESIC, New Delhi, which was previously running under sate government.

The ESI Act was passed in 1948 (amended in 1975, 1984 and 1989) and is an important measure of social security and health insurance in this country. It provides for certain cash and medical benefits to industrial employees in case of sickness, maternity and employment injury.

The Act extends to the whole of India and covers all power using factories other than seasonal factories, wherein 20 or more persons were employed (excluding mines, railways and defense establishments). The provisions of the ESI Act 1975 (amendment) were extended to some of the new classes of establishment those are; small power using factories employing 10 to 19 persons and non-power using factories employing 20 or more persons, shops, hotels and restaurants, cinemas and theaters, road motor transport establishments and newspaper establishments. With effect from 1 October 2006 the Act covers all employees manual, clerical, supervisory
and technical getting up to Rs. 10,000 per month. The provisions of the Act can be
extended to any other agricultural or commercial establishments.

The administration of the ESI scheme under the Act is entrusted to an
autonomous body called the ESI Corporation. The Union Minister and secretary,
Ministry of Labour, Government of India are Chairman and vice-Chairman
respectively. It consists of members representing central and state governments,
employers and employees’ organizations, medical profession and parliament. There is
a standing committee, constituted from members of the corporation, which act as an
executive body for the administration of the scheme. The chief executive officer of
the corporation is the Director general who was assisted by four principal officers (1)
Insurance Commissioner (2) Medical Commissioner (3) Finance Commissioner.
There is a Medical Benefit council, which is headed by the Director General of health
services, Government of India who is assisted by medical commissioner in all matters
related to medical relief. Beside the head office in New Delhi, the corporation has 23
regional offices and 12 sub regional offices and 844 local offices and cash offices all
over the country for administration of the scheme.

A huge number of beneficiaries receive medical benefit facilities through a
network of 1427 ESI dispensaries, over 2100 panel clinics, 307 diagnostic centers,
besides 143 ESI hospitals and 43 hospitals annexes with over 27000 beds. For super
specialty medical care the corporation has tie up an arrangement with advanced
medical institutions in the country, both public and private sector. The medical benefit
is administered with the active cooperation of state governments.

The scheme is run by the contribution of employees and employers and grants
from Central and State governments. The employer contributes 4.75 per cent of total
wage bill, the employee contributes 1.75 per cent of wages. Employees getting wages
below Rs. 50 are exempted from payment of contribution. The state governments
share of expenditure on medical care is 1/8 of total cost of medical care; ESI
corporation share of expenditure on medical care is 7/8 of total cost of medical care.

The act has made provision for selected benefits for insured person, those are;
medical, sickness, maternity, disablement, funeral rehabilitation and dependant’s
benefits. Medical benefits include full medical care including hospitalization, free of
cost to the insured person in case of sickness, employment injury and maternity. The
services include; out patient care, supply of drugs & dressings, specialist services,
investigations, domiciliary services, antenatal, natal and postnatal care, immunization,
family planning services, emergency services, ambulance services, health education
and inpatient treatment. In complicated cases where specialized treatment is necessary, patients are sent for institutional treatment even outside their state at the expenses of the ESI Corporation.

ESI Hospital, Ludhiana is situated in 10.5 acre land with 6 existing dispensaries and 90 staff quarters of different category. An extension of hospital was constructed in nineties with a provision to increase bed strength from 100 to 270. However, it was pending. New Hospital building was partially commissioned by Dr. Hardial Singh, the first Medical Superintendent of the ESI hospital, Ludhiana. Subsequently, present Medical superintendent, who took charge from Dr. Hardial Singh on 27th June 2005 was able to get the official sanction for 270 bedded hospital from ESIC Headquarters, New Delhi vide there letter U-16/18/1/ESIC/Chinchwad/2003-Med IV dated 10/01/06 because of consistent increase in bed occupancy.

At present ESI hospital is a 125-bedded (official sectioned- 125, actual is 270) super-speciality hospital. Patients requiring specialist consultation are referred to the hospital from ESI dispensaries. Hospital provides preventive, promotive, curative and rehabilitative care to about 3 lakh insured person-covering districts of Ludhiana, Ferozepur, Bathinda, Sangrur, in Punjab. Clients are provided out and in patient services which includes; emergency and specialty services, free drug supply, vaccination, dressing, x-rays, laboratory services, family welfare, therapeutic diet, ambulance services etc. The facilities, which are not available, are outsourced from other private health agencies (i.e. CT scan, MRI, EEG, TMT, ECHO etc.) patients who cannot be treated in this hospital are referred to PGIMER, Chandigarh or Rajindra hospital, Patiala. A tie up with the Red Cross Blood Bank compensates non-availability of the blood bank on nominal payment. Two ambulances are outsourced for patient transportation. This institute has following manpower to render hospital services:

Medical superintendent : 1  
Paramedical staff : 19  
IMO/GDO : 21  
Ministerial staff : 08  
RMO/SMO/MO : 17  
Class IV staff : 121  
Nurses : 61

Hospital has X-ray machine, Boyle’s apparatus, semi-auto analyzer, ECG machine, and fetal heart rate measuring Doppler. However, other emergency and critical care instruments were not available. ESI hospital provides general medicine, general surgery, gynecology and maternity, pediatrics, dental, eye, ENT, anesthesia
health care services. Hospital did not charge any thing for health care services. However it is run on the basis of contribution made by employee and employer of small industries as per ESI act.

ESI hospital has own dietary without dietician, one pharmacy, main store, record section, and mortuary. However hospital did not have Central Sterile Supply Department, sterile supply is managed by a small sized autoclave present in labour room and minor operation theater. Water purification plant is not available but water filters and water cooler are available at different points in hospital. There is no waste disposable plant, however, waste is segregated in colour codded bins by hospital staff but later managed by contract staff @ of 2.70 rupees per bed. Hospital does not have own laundry and transportation facilities, which are out sourced as per need. Unfortunately hospital has no facilities of canteen, library, reception/PRO, crèche, patients relative stay facilities and religious or spiritual facilities.

If one look into performance of ESI hospital, one can make out that, there is clear-cut improvement in hospital performance since hospital is over taken by ESIC, New Delhi. ESI hospital did not charge fee for health care services. However, small-scale industry employee and employer collectively contribute monthly for health care services. Only those employees who are insured in ESIC scheme can seek health services from this hospital. Therefore, patients seeking health services from this hospital are not to pay for any services. In addition if any service needed by patient is not available in the hospital, is then out sourced at free of cost for a patient.

Table 1.6: Performance indicators of ESI hospital during last five years

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OPDs</td>
<td></td>
<td>76112</td>
<td>76207</td>
<td>117939</td>
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<tr>
<td>IPDs</td>
<td></td>
<td>3128</td>
<td>4021</td>
<td>5125</td>
<td>7267</td>
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<tr>
<td>Deliveries</td>
<td></td>
<td>162</td>
<td>300</td>
<td>390</td>
<td>645</td>
<td>790</td>
</tr>
<tr>
<td>Minor operations</td>
<td></td>
<td>368</td>
<td>786</td>
<td>923</td>
<td>1557</td>
<td>1495</td>
</tr>
<tr>
<td>Major operations</td>
<td></td>
<td>466</td>
<td>835</td>
<td>939</td>
<td>881</td>
<td>886</td>
</tr>
<tr>
<td>Average bed occup. (%)</td>
<td></td>
<td>61%</td>
<td>73%</td>
<td>100%</td>
<td>130%</td>
<td>145%</td>
</tr>
<tr>
<td>Casualty attendance</td>
<td></td>
<td>744</td>
<td>2712</td>
<td>3831</td>
<td>5204</td>
<td>6148</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td></td>
<td>8334</td>
<td>32045</td>
<td>45380</td>
<td>58572</td>
<td>77104</td>
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<tr>
<td>X-rays</td>
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<td>1510</td>
<td>5448</td>
<td>7870</td>
<td>10030</td>
<td>12758</td>
</tr>
<tr>
<td>USG</td>
<td></td>
<td>NA</td>
<td>210</td>
<td>480</td>
<td>850</td>
<td>1045</td>
</tr>
<tr>
<td>Cost per bed/day</td>
<td></td>
<td>NA</td>
<td>1367</td>
<td>1214</td>
<td>1093</td>
<td>1122</td>
</tr>
</tbody>
</table>

Source: official documents of Medical Record Section, NA- Not available
**d) Civil Hospital** is a 130 bedded secondary care providing government hospital run by the Punjab Health System Corporation (PHSC). PHSC was set up in 1996–1997 covering 150 hospitals at the level of Community Health Centers, Sub division hospitals and District hospitals. Among these, 86 Medical Institutes are situated in rural and 64 in urban areas. The corporation upgraded the facilities with the aid of a soft World Bank loan (70 percent), state government (20 percent) and other loans (10 percent). User charges in the 150 hospitals are levied at the same rate as in other hospitals of the states. Collections through user charges are retained entirely by the hospital concerned, unlike the collections from hospitals, which are not covered by corporation. Thus, the burden of servicing the World Bank loan will be borne by the State Government, to which the charges levied on beneficiaries of the loan at present do not accrue. It is through that five years hence, user charges on all improved facilities could be enhanced. At that stage, there could perhaps be an earmarking of a portion of the enhanced user charges for serving the loan.

**Table 1.7: Performance indicators of Civil hospital during last five years**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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</thead>
<tbody>
<tr>
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<td>139172</td>
<td>140920</td>
<td>139475</td>
<td>182811</td>
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<tr>
<td>IPDs</td>
<td>6335</td>
<td>7458</td>
<td>6826</td>
<td>7492</td>
<td>10241</td>
</tr>
<tr>
<td>Deliveries</td>
<td>232</td>
<td>294</td>
<td>245</td>
<td>299</td>
<td>445</td>
</tr>
<tr>
<td>Minor operations</td>
<td>1068</td>
<td>5259</td>
<td>2574</td>
<td>4860</td>
<td>9646</td>
</tr>
<tr>
<td>Major operations</td>
<td>2306</td>
<td>2366</td>
<td>2626</td>
<td>2371</td>
<td>1850</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>35962</td>
<td>78349</td>
<td>57888</td>
<td>77793</td>
<td>152979</td>
</tr>
<tr>
<td>X-rays</td>
<td>11947</td>
<td>11519</td>
<td>12424</td>
<td>11481</td>
<td>22016</td>
</tr>
<tr>
<td>Average bed occupancy (%)</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
<td>90%</td>
<td>86%</td>
</tr>
<tr>
<td>Deaths</td>
<td>25</td>
<td>32</td>
<td>40</td>
<td>39</td>
<td>42</td>
</tr>
<tr>
<td>Users charges</td>
<td>2887639</td>
<td>3092978</td>
<td>2847881</td>
<td>3063155</td>
<td>4537251</td>
</tr>
</tbody>
</table>

*Source: official documents of Medical Record Section*

Hospital has following manpower to provide health care (on July 16, 2007):

- SMO : 01
- Nurses : 54
- MOs : 25
- Paramedical staff : 19
- EMOs : 05
- Ministerial staff : 05
- Dental doctors : 02
- Ancillary staff : 51
Civil hospital, Ludhiana is 130 bedded secondary level care providing government hospital. However there is no health care education and training establishment. Punjab Health System Corporation, Mohali has given grade A+ to Civil hospital, Ludhiana. Hospital has out patient services (includes medicine, surgery, skin, eye, ENT, orthopedics, pediatrics, psychiatric, dental, obstetrics and gynecological OPDs), laboratory, X-ray, ECG, blood bank and pharmacy facilities. Hospital has one dietary kitchen, central store, medical record section, mortuary, reception without Public Relation Officer, and three ambulances, one Punjab Health System run canteen. Hospital did not have Central Sterile Supply Department. However, sterile supply is managed by the small size autoclaves present in OT, Labour room and male ward dressing room. In addition, hospital is also deficit with water purification plant or water filters, therefore, one cannot ensure safety of drinking water. Hospital did not have library, crèche, religious/ spiritual facilities; facilities for stay of relatives and waste management plant. Hospital waste is managed by an out sourced contract facility.

1.14 Limitations of the Present Study

- Study was limited to inpatients. Patients seeking OPD services were not included in present study.
- Study was limited to general wards. Patients admitted in special units were not considered as study sample.
- Study was limited to opinions of the nurses about selected variables of nursing administration and ward management, doctors’ view points were not taken, because this study was limited to nursing care administration.

1.15 Objectives

1. To study nursing administration of selected hospitals.
2. To describe ward management of general wards in selected hospitals.
3. To assess the patients’ satisfaction with selected ward facilities/services.
4. To assess the patients’ satisfaction with nursing care.
5. To determine effect of patients’ socio-demographic characteristics on their satisfaction with ward facilities/services and nursing care.
6. To determine effect of selected variables (type and mode of admission, type of illness, history of surgery, number of hospitalizations, perceived level of pain, anxiety, patients’ perceived health status, prior contact with hospital, hospital’s image, and cost of care) on patients satisfaction with ward facilities/services and nursing care.

7. To study the relationship between patients’ satisfaction with nursing care and their willingness to continue health care services from same hospital or to recommend to others.

8. To suggest remedial measures to improve nursing administration, ward management and patients’ satisfaction with ward facilities/services and nursing care.

1.16 Hypotheses

The above said objectives were tested through the following hypothesis. The broad hypotheses of present study were to assess existing nursing care administration and patients’ satisfaction with ward facilities/services and nursing care in selected public and private hospitals. Following are the detailed hypotheses, which were tested during the course of study.

1. Nursing administration in private hospitals is better placed than government hospitals.

1.1 Location and facilities of nursing administrative office are better placed in private hospitals.

1.2 Organizational structure of nursing administration is better organized in private hospitals.

1.3 Staffing pattern in selected hospitals lacked the basic recommendations of Indian Nursing Council.

1.4 Nurse patient ratio is better in private hospitals.

1.5 Staff recruitment policies in selected hospitals are not in accordance with the recommendations of the Indian Nursing Council.

1.6 Promotional opportunities are better in private hospitals.

1.7 Staff training is better placed in private hospitals.

1.8 Staff wages and fringe benefits are better in government hospitals.
1.9 There is higher attrition rate among nursing personnel in private hospitals.
1.10 Job satisfaction among nurses is high in government hospitals.

2. Ward management is better placed in private hospitals than government hospitals.

2.1 Classification, location and layout of the wards are better placed in private hospitals.
2.2 Supportive service areas are better in wards of private hospitals as compared to government hospitals.
2.3 Sanitary facilities are in poor state in wards of the selected government and private hospitals.
2.4 Management of ward environment is better in wards of private hospitals.
2.5 Ancillary area is not given due place in government as well as private hospitals.
2.6 Miscellaneous ward facilities are better in private hospitals.
2.7 Nursing care is better organized in wards of private hospitals.

3. Patients’ satisfaction with ward facilities/services is low.

3.1 Overall patients’ satisfaction with ward facilities/services is low in selected hospitals.
3.2 Patients’ satisfaction with ward facilities/services is better in private hospitals as compared to government hospitals.
3.3 Patients’ satisfaction with ward facilities/services can not be similar in different wards of the selected hospitals.
3.4 Patients’ satisfaction with ward facilities/services is high in all the wards of private hospitals as compared to government hospitals.
3.5 The main areas of patients’ dissatisfaction with ward facilities/services are sanitary facilities, cleanliness, linen supply, waste segregation practices, drinking water facilities, and recreational facilities.
3.6 Patients’ satisfaction with all the selected ward facilities/services is more in private hospitals as compared to government hospitals.
3.7 Socio-demographic characteristics have significant effect on patients’ satisfaction with ward facilities/services.

a) Age: Aged patients are more satisfied with ward facilities/services.

b) Gender: Male patients are more satisfied with ward facilities/services.

c) Marital status: Married patients are more satisfied with ward facilities/services as compared to unmarried, divorced and widows/widowers.

d) Habitat: Rural patients are more satisfied with ward facilities/services.

e) Nativity: Migrated patients are more satisfied with ward facilities/services as compared to local native patients.

f) Religion: Religion does not effect the patients’ satisfaction with ward facilities/services.

g) Educational status: Illiterate or less educated patients are more satisfied with ward facilities/services.

h) Occupation: Professionals and businessmen are less satisfied with ward facilities/services.

i) Type of family: Patients belonging to joint families are more satisfied with ward facilities/services.

j) Per capita income: Poor patients are more satisfied with ward facilities/services.

3.8 Patients’ illness and hospitalization variables also have significant effect on patients’ satisfaction with ward facilities/services.

a) Type of admission: Patients admitted through planned mode are more satisfied with ward facilities/services.

b) Mode of admission: Referred patients are more satisfied with ward facilities/services.

c) Type of illness: Type of illness does not affect the patients’ satisfaction with ward facilities/services.

d) History of surgery: Operated patients are more dissatisfied with ward facilities/services.
e) **Total number of hospitalization**: More the number of hospitalization, higher the patients’ satisfaction with ward facilities/services.

f) **Number of hospitalization in the same hospital**: More the number of prior hospitalizations in the same hospital, higher the patients’ satisfaction with ward facilities/services.

g) **Pain**: Pain perception of patient reduces their satisfaction with ward facilities/services.

h) **Anxiety**: Anxious patients are less satisfied with ward facilities/services.

i) **Self rated health status**: Better the self rated health status of patients, higher the satisfaction with ward facilities/services.

j) **Total expenses on treatment**: Higher the cost of care, lesser the patients’ satisfaction with ward facilities/services.

k) **Preadmission hospital’s image**: Better the patients’ preadmission hospital image, higher the satisfaction with ward facilities/services.

4. Patients’ satisfaction with nursing care is low

4.1 Overall patients’ satisfaction with nursing care is low in selected hospitals.

4.2 Patients’ satisfaction with nursing care is high in private hospitals as compared to government hospitals.

4.3 Patients’ satisfaction with nursing care can not be similar in different clinical specialties.

4.4 Patients are more dissatisfied with communication and emotional support dimensions of nursing care.

4.5 Patients’ satisfaction in all the dimensions of the nursing care is high in private hospitals as compared to government hospitals.

4.6 Socio-demographic characteristics have significant effect on patients’ satisfaction with nursing care.

   a) **Age**: Aged patients are more satisfied with nursing care.

   b) **Gender**: Male patients are more satisfied with nursing care.

   c) **Marital status**: Married patients are more satisfied with nursing care.

   d) **Habitat**: Rural patients are more satisfied with nursing care.
e) **Nativity:** Migrated patients are more satisfied with nursing care as compared to local native patients.

f) **Religion:** Religion does not effect the patients’ satisfaction with nursing care.

g) **Educational status:** Illiterate or less educated patients are more satisfied with nursing care.

h) **Occupation:** Professionals and businessmen are less satisfied with nursing care.

i) **Type of family:** Patients belonging to joint families are more satisfied with nursing care.

j) **Per capita income:** Poor patients are more satisfied with nursing care.

4.7 Patients’ illness and hospitalization variables also have significant effect on patients’ satisfaction with nursing care.

a) **Type of admission:** Patients admitted through planned mode are more satisfied with nursing care.

b) **Mode of admission:** Referred patients are more satisfied with nursing care.

c) **Type of illness:** Type of illness does not affect the patients’ satisfaction with nursing care.

d) **History of surgery:** Operated patients are more dissatisfied with nursing care.

e) **Total number of hospitalization:** More the number of hospitalizations, higher the patients’ satisfaction with nursing care.

f) **Number of hospitalization in the same hospital:** More the number of hospitalizations in the same hospital, higher the patients’ satisfaction with nursing care.

g) **Pain:** Pain perception of patient reduces their satisfaction with nursing care.

h) **Anxiety:** Anxious patients are less satisfied with nursing care.

i) **Self rated health status:** Better the self rated health status of the patients, higher the satisfaction with nursing care.
j) **Total expenses on treatment:** Higher the cost of can patients’ satisfaction with nursing care.

k) **Preadmission hospital’s image:** Better the patients’ hospital image, higher the satisfaction with nursing care.

5. Higher the patients’ satisfaction with nursing care, more is the will to continue their health care services from the same hospital and to others.

1.17 Methodology

a) **Research design**

An integrated qualitative-quantitative descriptive design was used.

b) **Research area**

This study was conducted in Ludhiana. It is one of the centrally located cities of Punjab. Ludhiana city with 3762 sq. km area and total 2563340 population is known as the industrial hub of Punjab, whose roots go back to the 16th century. A vivacious city has turned out to be a colourful tree of different cultures and industrial status. Ludhiana has time and again been called the Manchester of Punjab.

![Fig. 1.3: Map of Punjab depicting Ludhiana](image)

Presently, Ludhiana has two private medical college hospital Medical College and Hospital, Dayanand Medical College and Hospital, government hospitals (ESI and Civil hospital) and other private hospitals like Mohan Dai Oswal Cancer Hospital, B.L. Kapur Memorial Hospital, etc.
Teg Bhadur Charitable Hospital, Phawa Charitable Medical Institute and some 70 more nursing homes and polyclinics catering to the health care needs of public. Christian Medical College and Hospital, Dayanand Medical College and Hospital, Civil hospital and ESI hospital are some of the most important health care organizations of the city, since they are catering the health care needs of largest segment of population not only from Ludhiana but also from adjoining areas including neighboring districts and states.  

**c) Methods of data collection**

Permission of data collection was sought from the competent authority of all the four hospitals. Primary data were collected by following methods.

I. Nursing administration data was collected from the nursing administrative office: Formal interviews were conducted with nursing administrators, nurses and nursing office records were reviewed for the collection of nursing administration related data. Individual nurses were given schedule to assess their opinions and satisfaction with different nursing administrative aspects and job related variables.

II. Case study: Case study was also conducted on 80 nurses to collect data pertaining to promotion, training and their intent to leave the organization.

III. Ward management related data was collected from selected wards: a formal in-depth interview was conducted with ward sisters, nurses and patients of the respective wards; ward records were reviewed to collect ward management related data. In addition, schedule was administered to individual nurses and patients to collect their opinions and satisfaction to different aspects of ward management.

IV. Patients’ satisfaction data: a formal interview was conducted with sampled patients to know their satisfaction with ward facilities/services and nursing care by using structured Patients’ Satisfaction Schedule. Only those patients were interviewed who have completed minimum one week stay in a ward.

Secondary data was collected from books, research journals, available records, bibliography and review of documents, both published and unpublished.
d) Population and sample

- Nursing administration was studied in each selected hospital by interviewing nursing administrators, nurses and review of nursing administrative office records.
- A total 200 nurses and nursing administrators were interviewed to know their opinion and satisfaction with selected variables of nursing administration. Sampling frame of randomly selected nurses and nursing administrators was as following:

**Fig. 1.4: Sampling frame for selection of respondents (nurses)**

```
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMC Hospital</td>
<td>50</td>
</tr>
<tr>
<td>DMC Hospital</td>
<td>50</td>
</tr>
<tr>
<td>ESI Hospital</td>
<td>50</td>
</tr>
<tr>
<td>CIVIL Hospital</td>
<td>50</td>
</tr>
</tbody>
</table>
```

In addition, a case study was conducted on 80 nurses by taking 20 nurses from each hospital. This case study was conducted to collect data regarding promotion, training and their intent to leave organization among nurses.

- Ward management was studied in general wards (medical, surgical, orthopedics and maternity) of selected hospitals by extensive observation of wards, review of ward records and interviewing nurses and patients of respective wards.
- A total 80 nurses were interviewed to collect data regarding their opinion and satisfaction with selected ward management variable. Sampling frame of randomly selected nurses was as following:

**Fig. 1.5: Sampling frame for selection of respondents (nurses)**

```
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMC Hospital</td>
<td>20</td>
</tr>
<tr>
<td>DMC Hospital</td>
<td>20</td>
</tr>
<tr>
<td>ESI Hospital</td>
<td>20</td>
</tr>
<tr>
<td>CIVIL Hospital</td>
<td>20</td>
</tr>
</tbody>
</table>
```
In addition, to assess the nurse’s knowledge about biomedical waste segregation, total 200 randomly selected nurses were given schedule, where 50 nurses were taken from each hospital.

- Patients’ satisfaction related data were collected from in-patients in four types of general wards (medical, surgical, orthopedics and maternity) of each selected hospital. Study sample of patients was selected by following inclusion and exclusion criteria.

**Inclusion criteria**

- Conscious patients who were willing to participate in study.
- Patients with more than one week stay in hospital.
- Patients admitted in general wards (medical, surgical, orthopedic, and maternity).
- Patient above the age of 18 years and who gave verbal consent to participate in study.

**Exclusion criteria**

- Patient/ family not willing to participate in study.
- Patients with sensory impairment.
- Disoriented patients.
- Patients with associated mental illness.

Total, 1200 patients were selected by using convenient sampling technique, where 300 patients were selected from each hospital by taking 75 patients from each ward i.e. medical (75), surgical (75), orthopedics (75) and maternity (75).

![Fig. 1.6: Sampling frame for selection of respondents (patients) from different hospitals](image-url)
e) Development of research instruments

Five different sets of tools were developed to collect data for different aspects of study variables.

- Nursing administration
- Nurses’ job satisfaction
- Ward management
- Patients’ Satisfaction Schedule

I. Nursing administration tool(s) was an interview cum observation proforma.

Nursing administration related data, which included detailed functions of nursing administrative office, location and facilities of nursing administrative office, organizational structure, staffing pattern, staff recruitment, staff training, pay structure, allowances, fringe benefits and attrition rate. In addition, schedule was designed to collect selected information from nurses relating to nursing administration, like nurses’ opinion and satisfaction with location and facilities of nursing administrative office, span of control, communication system, coordination, nurse patient ratio, promotional opportunities, pay, allowances, fringe benefits, training programs etc. Furthermore, focused group interviews were conducted to collect qualitative data related to nursing administration. A job satisfaction schedule was also designed and implemented to assess job satisfaction among nurses. A separate schedule was also designed to conduct case study to collect data from 80 nurses regarding opportunities of promotion, training and their intent to leave the organization.

II. Ward management tool(s) was also an interview cum observation proforma.

Ward management related data, which included details about classification, location, layout of wards, supportive service area, ward environment management, ancillary area, miscellaneous facilities, organization of nursing care, where a detailed observation was made in each ward and focused group interviews were conducted to collect qualitative data related to ward management. In addition, schedule was designed to collect selected information related to ward management from nurses, like nurses’ opinion and satisfaction with classification of wards, size, designs of wards, space available for each patient, overall ward layout, ward pantry, ward store,
patient's lockers, clean utility supply, linen supply, treatment room, dirty utility, ventilation, temperature control, lighting, noise control, hand washing facilities, cleanliness of ward, ancillary area, miscellaneous facilities, nursing station, nurses' rest room and method of patient care assignment. The patients were also interviewed to collect selected information related to ward management from patients like patients' opinion and satisfaction with classification of wards, size, space available for each patient, ward pantry, patient's lockers, linen supply, sanitary facilities, ventilation, temperature control, lighting, noise control, cleanliness of ward, ancillary area, miscellaneous facilities, and method of patient care assignment.

III. Patients' satisfaction Schedule was developed to collect data regarding patients' satisfaction with ward facilities/services and nursing care. Tool consisted of three parts.

- **Part-I: Patients' profile:** to collect socio-demographic, illness- hospitalization and personal history of the patients.

- **Part-II: Patients' satisfaction with selected ward facilities/services:** There were total twenty items to assess patients' satisfaction towards ward management. Each statement was asked to rate on four points Likerts' scale i.e. Highly satisfied, Moderately satisfied, Uncertain, dissatisfied and to each rating 3, 2, 1, 0 score was given respectively making a total maximum score of '60' and minimum zero. It was further divided into five sub score as follows:

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly satisfied</td>
<td>41 - 60</td>
</tr>
<tr>
<td>Moderately satisfied</td>
<td>21 - 40</td>
</tr>
<tr>
<td>Uncertain/ Dissatisfied</td>
<td>0 - 20</td>
</tr>
</tbody>
</table>

- **Part-III: Patients' Satisfaction with nursing care:** This part of tool was developed on basis of Watson (1979) eight dimensions of nursing care i.e. attentiveness, availability, emotional support, clinical and technical skills/ competences, interpersonal relationship, information and communication, knowledge and professionalism of nurses. There were total thirty-two items to collect data regarding patients' satisfaction with nursing care, consisting of four items under each dimension/ category of nursing care. Each statement
was judged to rate on four points Likert’s scale i.e. Highly satisfied, Moderately satisfied, Uncertain, dissatisfied and to each rating 3, 2, 1, 0 score was given respectively making a total maximum score of 96 and minimum zero. For each category/dimension maximum score was 12 and minimum was zero. Measurement for level of satisfaction was determined by following criterion measures:

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>Total score</th>
<th>Score for each dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly satisfied</td>
<td>65 – 96</td>
<td>9 – 12</td>
</tr>
<tr>
<td>Moderately satisfied</td>
<td>33 – 64</td>
<td>5 – 8</td>
</tr>
<tr>
<td>Uncertain/ Dissatisfied</td>
<td>0 – 32</td>
<td>0 – 4</td>
</tr>
</tbody>
</table>

f) Pilot study

The schedule was translated into Hindi, Punjabi and retranslated into English. Experts in the field of Hindi, Punjabi also validated the translation. A pilot study was undertaken on 20 patients in similar setting and few modifications were made in methodology and tool after consultation with experts. The respondents included in pilot study were not included in the study sample.

g) Ethical considerations

Written permission was taken from the competent authority before data collection from each hospital. Medical and nursing incharges of every ward were informed about data collection program to seek their cooperation. An informal consent was taken from all the respondents who participated in the study. The respondents were given freedom to participate or not to participate. Patients’ comfort was maintained during the interview and while interviewing nurses, care was taken that they were not disturbed during their patient care activities. Confidentiality of information and anonymity of subjects were ensured.

h) Data processing

Data was analyzed by using Statistical Package for Social Sciences (SPSS-16). Data was analyzed and interpreted by using descriptive as well as inferential statistics. Qualitative data was analyzed and interpreted with the help of narrations, descriptive indexing and photographs. Wherever needed data was presented with the help of tables and a hs.
1.18 Socio-demographic and illness-hospitalization profile of patients

Socio-demographic profile of the patients understudy is presented in Table 1.8. Total 1200 patients were selected from both government and private hospitals. Nearly half of the patients were in age group of 18 to 30 years, followed by about one fourth of the patients in the age group of 31 to 40 years. Similar pattern was seen in both types of selected hospitals. Nearly 20 percent of the subjects were in the age group of 46 to 50 years, which included 25 percent from private hospitals and 14.3 percent from government hospitals. Close to 10 percent patients belonged to the age group of sixty plus, which included 13 percent from private hospitals and 6.5 percent from government hospitals.

As per gender of patients, nearly equal number of male (53.8 percent) and female (46.2 percent) patients were included in the study. Majority of the patients i.e. 83.5 percent were married followed by 12.8 percent unmarried, 2.7 percent widow/widower and one percent divorced/ separated. Similar pattern was observed in both government and private hospitals.

As per habitat of patients, majority of them i.e. 61.8 percent were belonging to urban area, 37.8 percent from rural area. Similar pattern was observed in both government and private hospitals. However there were six patients from slums who got treatment in government hospitals, but in private hospitals there was no one in this category. As preferences of health care facility was concerned, majority of the Punjabis were seeking their health care from private hospitals and little less than fifty percent of the Punjabis were seeking their health care from government hospitals. About 50 percent of the patients seeking inpatient services in government hospitals were basically from UP and Bihar, while only 6.8 percent of them were seeking health care from private hospitals. Close to six percent of Himachali were seeking health care services from private hospitals and 1.5 percent of them were seeking health care from government hospitals.

Majority of the patients in government hospitals were Hindus (73.8 percent), followed by Sikhs (24.5 percent), Muslims and Christians (1.7 percent). Contrary to this in private hospitals nearly there were equal number of patients from Hindu and Sikh religion viz. Hindus (48.7 percent), Sikhs (46.3 percent) and five percent patients were Muslims and Christians.
## Table 1.8: Socio-demographic profile of patients

<table>
<thead>
<tr>
<th>Socio-demographic variables</th>
<th>Hospitals</th>
<th>Total</th>
<th>( \chi^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (in Years)</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 – 30</td>
<td>287 (47.8)</td>
<td>236 (39.3)</td>
<td>523 (43.6)</td>
</tr>
<tr>
<td>31 – 45</td>
<td>188 (31.3)</td>
<td>136 (22.7)</td>
<td>324 (27.0)</td>
</tr>
<tr>
<td>46 – 60</td>
<td>86 (14.3)</td>
<td>150 (25.0)</td>
<td>236 (19.7)</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>39 (06.5)</td>
<td>78 (13.0)</td>
<td>117 (09.7)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>329 (54.8)</td>
<td>317 (52.8)</td>
<td>646 (53.8)</td>
</tr>
<tr>
<td>Female</td>
<td>271 (45.2)</td>
<td>283 (47.2)</td>
<td>554 (46.2)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmarried</td>
<td>86 (14.3)</td>
<td>68 (11.3)</td>
<td>154 (12.8)</td>
</tr>
<tr>
<td>Married</td>
<td>495 (82.5)</td>
<td>507 (84.5)</td>
<td>1002 (83.5)</td>
</tr>
<tr>
<td>Divorced/ Separated</td>
<td>08 (01.3)</td>
<td>04 (00.7)</td>
<td>12 (01.0)</td>
</tr>
<tr>
<td>Widowed/ widower</td>
<td>11 (01.8)</td>
<td>21 (03.5)</td>
<td>32 (02.7)</td>
</tr>
<tr>
<td><strong>Habitat</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>223 (37.2)</td>
<td>230 (38.3)</td>
<td>453 (37.8)</td>
</tr>
<tr>
<td>Urban</td>
<td>371 (61.8)</td>
<td>370 (61.7)</td>
<td>741 (61.8)</td>
</tr>
<tr>
<td>Slum</td>
<td>06 (01.0)</td>
<td>00 (00.0)</td>
<td>06 (00.5)</td>
</tr>
<tr>
<td><strong>Nativity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punjab</td>
<td>275 (45.8)</td>
<td>486 (81.0)</td>
<td>761 (63.4)</td>
</tr>
<tr>
<td>Utter Pradesh</td>
<td>155 (25.8)</td>
<td>26 (04.3)</td>
<td>181 (15.1)</td>
</tr>
<tr>
<td>Bihar</td>
<td>145 (24.2)</td>
<td>15 (02.5)</td>
<td>160 (13.3)</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>09 (01.5)</td>
<td>34 (05.7)</td>
<td>43 (03.6)</td>
</tr>
<tr>
<td>Others</td>
<td>16 (02.7)</td>
<td>39 (06.5)</td>
<td>55 (04.6)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>443 (73.8)</td>
<td>292 (48.7)</td>
<td>734 (61.2)</td>
</tr>
<tr>
<td>Sikh</td>
<td>147 (24.5)</td>
<td>278 (46.3)</td>
<td>425 (35.4)</td>
</tr>
<tr>
<td>Muslim/ Christian</td>
<td>10 (01.7)</td>
<td>30 (05.0)</td>
<td>40 (03.4)</td>
</tr>
<tr>
<td><strong>Educational Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>230 (38.3)</td>
<td>123 (20.5)</td>
<td>353 (29.4)</td>
</tr>
<tr>
<td>Primary</td>
<td>84 (14.0)</td>
<td>65 (10.8)</td>
<td>149 (12.4)</td>
</tr>
<tr>
<td>Middle</td>
<td>116 (19.3)</td>
<td>68 (11.3)</td>
<td>184 (15.3)</td>
</tr>
<tr>
<td>Matric</td>
<td>96 (16.0)</td>
<td>147 (24.5)</td>
<td>243 (20.2)</td>
</tr>
<tr>
<td>10+2</td>
<td>48 (08.0)</td>
<td>93 (15.5)</td>
<td>141 (11.8)</td>
</tr>
<tr>
<td>Graduate</td>
<td>18 (03.0)</td>
<td>75 (12.5)</td>
<td>93 (07.8)</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>08 (01.3)</td>
<td>29 (04.8)</td>
<td>37 (03.1)</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non working</td>
<td>268 (44.7)</td>
<td>282 (47.0)</td>
<td>550 (45.8)</td>
</tr>
<tr>
<td>Non-skilled</td>
<td>144 (24.0)</td>
<td>145 (24.2)</td>
<td>289 (24.2)</td>
</tr>
<tr>
<td>Skilled</td>
<td>73 (12.2)</td>
<td>66 (11.0)</td>
<td>139 (11.6)</td>
</tr>
<tr>
<td>Professional/ business</td>
<td>15 (02.5)</td>
<td>107 (17.8)</td>
<td>122 (10.2)</td>
</tr>
</tbody>
</table>

Computed from primary data, *Figure in parentheses are percentage.*
*Mean age of government hospital patients = 35.43±3.50;*  
*Mean age of private hospital patients = 40.77±16.25;*  
*Mean age of overall total patients = 38.10±5.17*
Majority of patients in government hospitals, i.e. 87.6 percent were matric or below educated, whereas in private hospitals only 66.6 percent patients were in this category. In government hospitals there were only 4.3 percent patients who were graduates or above, while in private hospitals this category included 17.3 percent patients. Higher number of patients (38.3 percent) were illiterate, who were seeking care in government hospitals as compared to private hospitals (20.5 percent). Nearly equal number of nonworking people were seeking health care from government and private hospitals. Higher number of non-skilled people were seeking health care from government hospitals (40.7 percent) as compared to private hospitals (24.2 percent). More number of professionals/businessmen were seeking health care from private hospitals (17.8 percent) as compared to government hospitals (2.5 percent).

Table 1.9: Family history of patients

<table>
<thead>
<tr>
<th>Family history variables</th>
<th>Hospitals</th>
<th>Total</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government (n=600)</td>
<td>Private (n=600)</td>
<td></td>
</tr>
<tr>
<td><strong>Type of family</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear</td>
<td>448 (74.7)</td>
<td>297 (49.5)</td>
<td>745 (62.1)</td>
</tr>
<tr>
<td>Joint</td>
<td>152 (25.3)</td>
<td>303 (50.5)</td>
<td>455 (37.9)</td>
</tr>
<tr>
<td><strong>Family members</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 3</td>
<td>130 (21.7)</td>
<td>81 (13.5)</td>
<td>211 (17.6)</td>
</tr>
<tr>
<td>4 – 6</td>
<td>384 (64.0)</td>
<td>314 (52.3)</td>
<td>698 (58.2)</td>
</tr>
<tr>
<td>7 – 9</td>
<td>65 (10.8)</td>
<td>125 (20.8)</td>
<td>190 (15.8)</td>
</tr>
<tr>
<td>&gt; 10</td>
<td>21 (03.5)</td>
<td>80 (13.3)</td>
<td>101 (08.4)</td>
</tr>
<tr>
<td><strong>Monthly family Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 5000</td>
<td>485 (80.5)</td>
<td>222 (37.0)</td>
<td>707 (58.9)</td>
</tr>
<tr>
<td>5001 – 10000</td>
<td>102 (17.0)</td>
<td>228 (38.0)</td>
<td>330 (27.5)</td>
</tr>
<tr>
<td>10001 – 15000</td>
<td>03 (00.5)</td>
<td>66 (11.0)</td>
<td>69 (05.8)</td>
</tr>
<tr>
<td>15001 – 20000</td>
<td>06 (01.0)</td>
<td>37 (06.2)</td>
<td>43 (03.6)</td>
</tr>
<tr>
<td>&gt; 20000</td>
<td>04 (00.7)</td>
<td>47 (07.8)</td>
<td>51 (04.2)</td>
</tr>
<tr>
<td><strong>Per capita income (Rs.)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 1000</td>
<td>437 (72.8)</td>
<td>245 (40.8)</td>
<td>682 (56.8)</td>
</tr>
<tr>
<td>1001 – 2000</td>
<td>138 (23.0)</td>
<td>200 (33.3)</td>
<td>338 (28.2)</td>
</tr>
<tr>
<td>2001 – 3000</td>
<td>10 (01.7)</td>
<td>53 (08.8)</td>
<td>63 (05.2)</td>
</tr>
<tr>
<td>3001 – 4000</td>
<td>09 (01.5)</td>
<td>41 (06.8)</td>
<td>50 (04.2)</td>
</tr>
<tr>
<td>4001 – 5000</td>
<td>00 (00.0)</td>
<td>21 (03.5)</td>
<td>21 (01.8)</td>
</tr>
<tr>
<td>&gt; 5000</td>
<td>06 (01.0)</td>
<td>40 (06.7)</td>
<td>46 (03.8)</td>
</tr>
</tbody>
</table>

Computed from primary data
# Figure in parentheses are percentage
Table 1.10: Mean distribution of selected variables of family history among patients

<table>
<thead>
<tr>
<th>Family history variables</th>
<th>Hospitals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government</td>
<td>Private</td>
</tr>
<tr>
<td>Family members</td>
<td>4.87 ± 02.02</td>
<td>6.23 ± 03.05</td>
</tr>
<tr>
<td>Monthly family Income</td>
<td>4033.50 ± 6612.00</td>
<td>11236.67 ± 22553.60</td>
</tr>
<tr>
<td>Per capita income</td>
<td>882.91 ± 1030.83</td>
<td>2282.01 ± 5359.38</td>
</tr>
</tbody>
</table>

*Computed from primary data

# Figure in parentheses are percentage

Family history of patients may be perused from Table 1.9 and 1.10. In private hospitals, nearly equal number of patients were from nuclear or joint families. While in government hospitals, more number of patients were from nuclear families (74.7 percent) as compared to joint families (25.3 percent). Majority of patients i.e. 85.7 percent seeking health care from government hospitals were having less than six members in family (with 4.87±02.02 mean family members), while patients seeking health care in private hospitals were only 65.8 percent in this category (with 6.23±03.05 mean family members). Majority of patients i.e. 80.5 percent seeking health care in government hospitals were having monthly family income less than Rs.5000 (with 4033.50±6612.00 mean monthly family income), whereas there were only 37 percent patients in this category (with 11236.67±22553.60 mean monthly family income), who were seeking health care in private hospitals. In addition, majority of patients i.e. 72.3 percent seeking health care in government hospitals were having per capita income less than thousand rupees per month (with 882.91±1030.83 mean monthly per capita income), while there were only 40.8 percent patients were in this category (with 2282.01±5359.38 mean monthly per capita income), who were seeking health care in private hospitals.
Table 1.11: Illness and hospitalization profile of patients

<table>
<thead>
<tr>
<th>Variables</th>
<th>Hospitals</th>
<th>Total</th>
<th>( \chi^2 )</th>
<th>d. f.</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government (n=600)</td>
<td>Private (n=600)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency</td>
<td>334 (55.7)</td>
<td>301 (50.2)</td>
<td>635 (52.9)</td>
<td>3.642</td>
<td>1</td>
</tr>
<tr>
<td>Planned (Elective)</td>
<td>266 (44.3)</td>
<td>299 (49.8)</td>
<td>565 (47.1)</td>
<td>0.056</td>
<td></td>
</tr>
<tr>
<td>Mode of hospital admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred by Physician</td>
<td>78 (13.0)</td>
<td>129 (21.5)</td>
<td>207 (17.2)</td>
<td>19.009</td>
<td>2</td>
</tr>
<tr>
<td>Advised by family/ friends</td>
<td>311 (51.8)</td>
<td>309 (51.5)</td>
<td>620 (51.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>211 (35.2)</td>
<td>162 (27.0)</td>
<td>373 (31.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>374 (62.3)</td>
<td>348 (58.0)</td>
<td>722 (60.2)</td>
<td>9.697</td>
<td>2</td>
</tr>
<tr>
<td>Chronic</td>
<td>93 (15.5)</td>
<td>135 (22.5)</td>
<td>228 (19.0)</td>
<td>0.008</td>
<td></td>
</tr>
<tr>
<td>Physiological</td>
<td>133 (22.2)</td>
<td>117 (19.5)</td>
<td>250 (20.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underwent of surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>146 (24.3)</td>
<td>289 (48.2)</td>
<td>435 (36.2)</td>
<td>73.740</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>454 (75.7)</td>
<td>311 (51.8)</td>
<td>765 (63.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total hospitalization in life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once only</td>
<td>364 (60.7)</td>
<td>260 (43.3)</td>
<td>624 (52.0)</td>
<td>37.345</td>
<td>2</td>
</tr>
<tr>
<td>2 – 5</td>
<td>223 (37.2)</td>
<td>313 (52.2)</td>
<td>536 (44.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;5</td>
<td>13 (02.2)</td>
<td>27 (04.5)</td>
<td>40 (03.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission in present hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once only</td>
<td>488 (81.3)</td>
<td>407 (67.8)</td>
<td>895 (74.6)</td>
<td>33.033</td>
<td>2</td>
</tr>
<tr>
<td>2 – 5</td>
<td>108 (18.0)</td>
<td>173 (28.8)</td>
<td>281 (23.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;5</td>
<td>04 (0.7)</td>
<td>20 (03.3)</td>
<td>24 (02.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses in hospital (Rs.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>201 (33.5)</td>
<td>25 (04.2)</td>
<td>226 (18.0)</td>
<td>755.8</td>
<td></td>
</tr>
<tr>
<td>&lt; 1000</td>
<td>181 (30.2)</td>
<td>05 (00.8)</td>
<td>186 (15.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1000 – 5000</td>
<td>203 (33.8)</td>
<td>107 (17.8)</td>
<td>310 (25.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5001 – 10000</td>
<td>13 (02.2)</td>
<td>141 (23.5)</td>
<td>154 (12.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10001 – 20000</td>
<td>02 (0.3)</td>
<td>123 (20.5)</td>
<td>125 (10.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20001 – 50000</td>
<td>00 (00.0)</td>
<td>106 (17.7)</td>
<td>106 (08.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 50000</td>
<td>00 (00.0)</td>
<td>93 (15.5)</td>
<td>93 (07.8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Computed from primary data
# Figure in parentheses are percentage
Table 1.12: Mean score of selected variables in family history among patients

<table>
<thead>
<tr>
<th>Family history variables</th>
<th>Hospitals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government</td>
<td>Private</td>
</tr>
<tr>
<td>Total hospitalization in life</td>
<td>1.7 ± 1.5</td>
<td>2.2 ± 2.1</td>
</tr>
<tr>
<td>Admission in present hospital</td>
<td>1.3 ± 0.8</td>
<td>1.7 ± 1.9</td>
</tr>
<tr>
<td>Expenses in hospital</td>
<td>1218.33 ± 2027.27</td>
<td>33475.67 ± 64197.25</td>
</tr>
</tbody>
</table>

Computed from primary data,
# Figure in parentheses are percentage

Illness and hospitalization profile of patients may be perused from Table 1.11 and 1.12. In both government and private hospitals, there were equal number of patients admitted through emergency and planned way. Half of the patients in both government and private hospitals were admitted because their family or friends advised them so. Referral admissions in government hospitals were less (13 percent) as compared to private hospitals (21.5 percent). Self directed admissions were more in government hospitals (35.2 percent) as compared to private hospitals (27 percent). Type of illness pattern was nearly similar in government as well as private hospitals. However chronically ill patients were slightly more in privates hospitals (22.5 percent) as compared to government hospitals (15.5 percent).

Nearly equal number of patients in private hospitals were with or without operative history. However, in government hospitals, only one fourth of subjects had operative history. In government hospitals, 60.7 percent subjects were having single lifetime hospitalization history, while in private hospitals only 43.3 percent subjects were in this category. Only 2.2 percent patients had greater than 5 lifetime hospitalization history in government hospitals, while there were 4.5 percent patients in private hospitals in this category.

Majority of patients i.e. 81.3 percent in government hospitals were admitted for the first time, while there were 67.8 percent subjects in private hospitals, who were first time admitted. There were 32.1 percent subjects in private hospitals admitted more than two times in same hospital, while there were less than one percent (0.7 percent) of such patients in government hospitals. In government hospitals 33.5 percent subjects got health care services at free of cost, rest of them paid for health care services, out of them majority paid less than 5000 rupees during hospitalization.
Mean expenses in government hospitals were 1218.33 ± 2027.27. In private hospitals only 4.2 percent patients got health care services free of cost, which was so because they were hospital employees. More than half of the patients in private hospitals, paid between 10001 to > 50000 during hospitalization. Mean expenses in government hospitals was 33475.67 ± 64197.25.

Table 1.13: Patient’s self perceived pain, anxiety, health status and hospital image

<table>
<thead>
<tr>
<th>Patients’ perception of….</th>
<th>Hospitals</th>
<th>Total</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government (n=600)</td>
<td>Private (n=600)</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>271 (45.2)</td>
<td>185 (30.8)</td>
<td>455 (37.9)</td>
</tr>
<tr>
<td>Absent</td>
<td>329 (54.8)</td>
<td>415 (69.2)</td>
<td>745 (62.0)</td>
</tr>
<tr>
<td>Level of pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pain</td>
<td>329 (54.8)</td>
<td>415 (69.2)</td>
<td>744 (62.0)</td>
</tr>
<tr>
<td>Mild</td>
<td>87 (14.5)</td>
<td>53 (08.8)</td>
<td>140 (11.7)</td>
</tr>
<tr>
<td>Moderate</td>
<td>109 (18.2)</td>
<td>97 (16.2)</td>
<td>206 (17.2)</td>
</tr>
<tr>
<td>Sever</td>
<td>65 (10.8)</td>
<td>25 (04.2)</td>
<td>90 (07.5)</td>
</tr>
<tr>
<td>Intolerable</td>
<td>10 (01.7)</td>
<td>10 (01.7)</td>
<td>20 (01.7)</td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>106 (17.7)</td>
<td>88 (14.7)</td>
<td>194 (16.2)</td>
</tr>
<tr>
<td>Absent</td>
<td>494 (82.3)</td>
<td>512 (85.3)</td>
<td>1006 (83.8)</td>
</tr>
<tr>
<td>Level of anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No anxiety</td>
<td>494 (82.3)</td>
<td>512 (85.3)</td>
<td>1006 (83.8)</td>
</tr>
<tr>
<td>Mild</td>
<td>33 (05.5)</td>
<td>28 (04.7)</td>
<td>61 (05.1)</td>
</tr>
<tr>
<td>Moderate</td>
<td>44 (07.3)</td>
<td>43 (07.2)</td>
<td>87 (07.3)</td>
</tr>
<tr>
<td>Sever</td>
<td>24 (04.0)</td>
<td>10 (01.7)</td>
<td>34 (02.8)</td>
</tr>
<tr>
<td>Intolerable</td>
<td>05 (00.8)</td>
<td>08 (01.3)</td>
<td>13 (01.1)</td>
</tr>
<tr>
<td>Health status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>18 (03.0)</td>
<td>69 (11.5)</td>
<td>87 (07.3)</td>
</tr>
<tr>
<td>Fair</td>
<td>549 (91.5)</td>
<td>503 (83.3)</td>
<td>1052 (87.7)</td>
</tr>
<tr>
<td>Poor</td>
<td>33 (05.5)</td>
<td>28 (04.7)</td>
<td>61 (05.1)</td>
</tr>
<tr>
<td>Hospital image</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>43 (07.2)</td>
<td>185 (30.8)</td>
<td>228 (19.0)</td>
</tr>
<tr>
<td>Fair</td>
<td>150 (25.0)</td>
<td>368 (61.3)</td>
<td>518 (43.2)</td>
</tr>
<tr>
<td>Poor</td>
<td>334 (55.7)</td>
<td>02 (00.3)</td>
<td>336 (28.0)</td>
</tr>
<tr>
<td>Uncertain</td>
<td>73 (12.2)</td>
<td>45 (07.5)</td>
<td>118 (09.8)</td>
</tr>
</tbody>
</table>

Computed from primary data
# Figure in parentheses are percentage
Table 1.13 illustrates patient’s self-perceived pain, anxiety, health status and hospital image related data. In government hospitals pain control of patients was poor since 45.2 percent patients were experiencing pain at the time of interview, while in private hospitals only 30.8 percent patients verbalized pain perception at the time of interview. In government hospitals moderate to severe level of pain was experienced by 30.7 percent, while there were only 22.1 percent patients in private hospitals in this category. Slightly more number of patients experienced anxiety in government hospitals (17.7 percent) as compared to private hospitals (14.7 percent). Severe level of anxiety was experienced by four percent patients in government hospitals and three percent patients in private hospitals. More number of patients in private hospitals (11.5 percent) perceived good level of health status at the time of interview as compared to patients in government hospitals (3 percent). Poor level of health status was perceived by nearly similar number of patients in government (5.5 percent) and private hospitals (4.7 percent).

Data about prior admission hospital’s image among patients revealed that just more than half (55.7 percent) of the patients in government hospitals were admitted inspite of poor perceived hospital’s image before admission, 25 percent of them had fair and only few (7.2 percent) had good perceived hospital’s image before admission. On other hand, majority of patients in private hospitals had good (30.8 percent) and fair (61.3 percent) image of hospitals before admission. Very less number of patients in private hospitals i.e. 0.3 percent had poor hospital image prior to admission in these hospitals.

1.18 Chapterisation

Chapter 1: Background and methodology of study.

Chapter 2: Nursing administration in selected hospitals.

Chapter 3: Ward management in selected hospitals.

Chapter 4: Patients’ satisfaction with selected ward facilities/services.

Chapter 5: Patients’ satisfaction with nursing care.

Chapter 6: Conclusion and recommendations.
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