CHAPTER -II

REVIEW OF LITERATURE
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INTRODUCTION

The literature review is an important step in any research process. Review of earlier studies discloses the works and studies done by individual researchers and institutions and help to establish further the need for the study. Reports of surveys undertaken by the government and the non-government agencies provide very useful information to the research process. Various studies relating to the role and functioning of health services have been conducted by different social scientists at micro as well as macro level in India and Broad. While there has been much literature available about the healthcare services and their administration, it is found in the study that Customer Relationship Management in private hospital and maintaining relationship with patients and providing services to them.

2.1 INITIAL SERVICES

Initial service brings about an interface between the hospital and the community, which is emotionally surcharged. The casualty department provides the first impression on the patient, relatives and friends who come along with the patient. The first impression must be a positive one. Quick and competent care can save lives and also reduces the severity and duration of illness.

Alexander Wyke, in his study on Healthcare Services in the US, points out that healthcare in the US is changing rapidly from the traditional system, where the hospitals and clinics are administered largely by government and non-profit

organizations to the modern system giving way to a regime of managed care run increasingly by the private sector. He has felt that in spite of all these changes the public is complaining more and more about low standards of medical practice, long waiting times, inapt diagnosis and blatant errors of medical judgment. He points that patients are becoming more demanding consumers and that healthcare ultimately will be led by the dictates of the consumer instead of by the government or industry initiatives. He feels that the future of medicine is at home and medical science is shifting from specialization towards holism.

Curry and Sinclair\textsuperscript{2} his study found that patients' highest expectations were with respect to feeling safe during treatment, with staff behaving in such a way as to instill confidence and having the knowledge to answer patients' questions following close behind in terms of importance. Patients also expected staff to have their best interest at heart, understand their specific needs and be able to show a sincere interest in solving patient problems.

DeMan, S.P.Gemmel, P.Vlerick, P.V.Rijk& R. Dierckx\textsuperscript{3} stated that actively managing consumer perceptions of healthcare quality is important for several reasons. First, evaluations of higher quality are related to satisfaction, intention to use a service again in the future if necessary, compliance with advice and treatment regimens, choice of provider or plan, decreased turnover and malpractice law suits, and possibly better health outcomes. In addition, high levels of consumer-perceived quality have been shown to be positively related to financial performance in


healthcare organizations. This study also shows the strong relationship between overall service-quality perception and patient satisfaction. There seems to be no congruence between personnel's views and patients' views, measured on service quality dimensions, and healthcare personnel seem to underestimate overall patient satisfaction.

Inganzo\textsuperscript{4} carried out a study to determine the level of patient's satisfaction with five factors relating to hospital stay. Nursing care appearance of the room, attitude of the hospital staff, and quality of the food and billing procedures. It was found that perception of non-medical factors played a substantial role in the patients overall evaluation of his hospital and it was suggested that every hospital should implement a mechanism to obtain reliable feedback from patients regarding various aspects of their stay and in the areas where was substantial patients dissatisfaction efforts should be made to determine the reasons for dissatisfaction and programme be set up to the eliminate dissatisfaction.

Kimes and Mutkowski\textsuperscript{5} defined a process as the actual procedures, mechanisms and flow of activities by which the service is delivered, i.e., the service delivery and the operating system. Design tools such as the blueprint and process flowchart have been borrowed from the manufacturing domain and used to diagram the important elements of the service process, including the customer point of entry, customer participation in process steps and point of exit from the service delivery system. Caution symbols are built into blueprints to warn managers and employees of potential fail points, bottlenecks and customer wait periods.

\textsuperscript{4} Inganzo, Joe (1985). Consumer satisfaction with hospitalization, Hospitals, May, 81-83.

Marraro states that health care leaders and trustees must ensure that patient safety becomes (and stays) one of the organization's primary goals and business imperatives. The ethical imperative for patient safety (First, do no harm), represents the fundamental philosophy of medical care dating back to ancient Greece and the physician’s Hippocratic Oath. This dimension assesses the patient’s view of the overall experience of medical care he/she received at this hospital.

Madhu in his study on Sociological Analysis of Patient and his illness, observes that a large number of diseases were associated with the socio-economic status and other socio-cultural and demographic factors of individuals and groups. He examines some of these factors in relation to the patients in order to understand the aetiology of the disease and also the patient’s predisposition or motivation to seek medical intervention. He points out that people’s perception of health is diffused rather than specific because their socio-cultural environments, which are changing, and in most situations are transitional, i.e., shifting from traditional to modern.

Mukherjee, in their study on Health as Development-Implications for Research, Policy and Action, draw attention to some of the major issues that emerged from the discussions in the workshop on the “Future of Health and Population in India’s Development”, which was intended to take stock of health achievements and to stimulate new thinking on policy initiatives. They feel that despite India’s spectacular achievement in many fields, there is much to be accomplished in the area

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of health. They stress the need for immediate priority to be assigned for new policy initiatives in the social sector in general and health in particular. They are of the opinion that policymakers need to recognize the primacy of good health as an essential component of human development in India and policy interventions need to be more people-focused, broad-based and multi-pronged. They have made a study on assessment of health performance and feel the need to stimulate demand for health services through education and awareness building and to re-examine the whole structure of financial and political incentives underlying government’s resource allocation within a democratic framework.

Overtveit\(^9\) recognized the three “stakeholder” components of quality, namely client, professional and management quality. He stated that high service quality is a combination of providing patients with what they want (customer quality), with what they need (professional quality) and at the lowest cost, without errors and within higher-level regulations and directives (management quality). In a study by DeMan\(^{10}\) the importance of service quality in affecting patient satisfaction was shown, providing justification for marketing activity to measure and improve customer satisfaction with service encounters in ambulatory care clinics. Here he proposed a combination of patient, care (e.g. relatives), referrer (e.g. a doctor deciding that a person needs a hospital service), and a purchaser or a financing authority. Each party has needs and expectations which the service provider must understand, and reconcile when they are different-this is only possible if the service provider has a good relationship with each.


\(^{10}\) De Man, ibid
Shostack\(^\text{11}\) described the blueprint as a depiction of the steps comprising the delivery of a service process and suggested that it is a tangible entity that can be used to educate customers about the service system in a firm, as well as to invite feedback for competitive assessments or new process design. This dimension covers the treatment process and the outcome of the treatment process has examined the degree to which physician-patient congruence in preference for patient involvement is related to self-reported satisfaction, adherence, and health. Results showed that when patients and their doctors shared similar beliefs about patient participation, patient outcomes tended to be more positive, with highest satisfaction found in cases in which both patient and physician desired more patient involvement.

Shemwell et al\(^\text{12}\) reported that studies have shown service quality perceptions as an outcome of satisfaction. The level of satisfaction is an important indicator of a consumer's state of mind, and patients with different levels of satisfaction may react in different ways. Satisfied consumers, for instance, engage in positive word-of-mouth, that is they tell others of their pleasure with the service provider and the service. Complaints can be directed at the service provider or his/her proxies. As Gelb and Johnson\(^\text{13}\) stated, when patients find it difficult to complain to the health care service provider himself/herself because of their culture or because of the service provider's procedures, they disparage the service provider to others. A highly satisfied patient, on the other hand, has little or no cause for complaint. Results

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show that improving service emotional bonding, and an increased propensity to remain a patient of the focal doctor. The problem here is that the patient in many cases does not have enough knowledge, training or skill to make a logical, rational, supraliminal service quality evaluation.

Smidts and Pruyn\textsuperscript{14} studied health-care customers in out-patient clinics, and found that perceived waiting times tended to affect the patient’s evaluation of the wait more than the actual waiting times. Customer perception of the length of waiting times did not change when distractions were provided. First, it may be that distraction does not actually affect the perception of waiting time. Alternatively, it may be that the distraction was not the appropriate distraction, given the context of the wait. It is quite possible, for example, that a television in an outpatient setting is more of an irritant than a positive distraction for people who may be ill, or if well, apprehensive about their visits.

Sarma\textsuperscript{15} has analyzed the demographic implications of the goals of “Health for all by 2000 A.D.” He observes that though mortality is falling, morbidity is increasing and correspondingly healthcare services are not improving. He feels that unless drastic steps are taken to improve the quality of healthcare delivery system, it would be very difficult to achieve significant reductions in infant mortality rate and maternal mortality rate. He identifies that poverty and food scarcity are the basic problems hampering the improvement of health status of the people. Thus, he


\begin{flushleft}\textsuperscript{15}Sarma P.V.S., “Demographic implications of Health for all by 2000 A.D.”, Health Planning in India, A.P.H. Publishing Corporation, New Delhi, 1997, pp.67-70.\end{flushleft}
suggests that attack on poverty and controlling population growth are the twin approaches to achieve the goal of health for all.

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Thomasson\textsuperscript{19} showed that the customer perception of quality can be described in a number of categories with confidence of the personnel as the overarching category, and honesty/reliability/responsibility, personal contact, accessibility/willingness/attitude and competence as subcategories and integrated these findings and provide a list of six criteria of good perceived service quality; professionalism and skills, attitudes and behavior, accessibility and flexibility, reliability and trustworthiness, recovery, and reputation and credibility.

Thaper\textsuperscript{20}, in his study Health and Development, deals with the problems of health. He advocates the need for immunization of children up to 6 years against various diseases; to organize campaigns against prevalent diseases, provide anti-natal care to all pregnant women, provide nutrition supplements to expectant mothers, and

\textsuperscript{18} Shostack ,ibid


\textsuperscript{20} Thaper S.D., health and development ,association of voluntary agencies for rural development ,New Delhi 1977
improve services and techniques of indigenous medicines to integrate the services of Ayurvedic doctors with the total health system. He has devoted much attention towards the health of women and children

Venkatesha\textsuperscript{21} in his study Marketing of Medical Services and Consumer Protection stresses the important role played by the medical service organizations in providing basic healthcare services to the consumers. He discusses the major symptoms of ill health of medical service, which include medical negligence, deficiency and low quality service, lack of continued medical education, irrational drug policy and lack of holistic approach in the medical system and feels that the adoption of marketing concept in medical services is the answer to many ills besetting medical services in India. Venkatesha is of the opinion that consumer protection and satisfaction are the core concepts of modern marketing.

\subsection*{2.2 FACILITIES FOR INPATIENTS AND OUT PATIENTS}

This dimension assesses the patient's perception of quality with regard to the physical facilities in the hospital. This includes the cleanliness, maintenance and availability of services such as waiting rooms, diagnostic test rooms, operation theatres, wards, food, beds, resident rooms, ambulance services, technological capability, pharmacy, blood banks, etc. Several studies have attempted to study the importance of the physical facilities, infrastructure or tangibles, in service delivery.

Asha Krishnakumar\textsuperscript{22} Private Sector perhaps aware of its own limitations and need to attract more investments in the medical field, the state government offered subsidies, soft loans, duty exemptions and so on to private investors. Most of the private hospitals have their own investigative facilities with the latest equipments and modern laborites, blood banks and scanning centers that offer high quality, reliable diagnostic facilities, and several private organizations that provide high quality squires fault the government for the poor infrastructure.

Nayar\textsuperscript{23}, in his study on public medicare has felt that the government has not made any serious assessment of the existing maladies that effect public health in the country even after stepping into 2000 A.D. He points that inadequate access to healthcare in India is due to lack of sufficient number of medicare facilities and adequate care available in them. He points that variation in the availability of specialists, paramedical staff, and facilities for medical investigations, physical infrastructure and the complementary nature of these inputs are responsible for the differential utilization of health centers. He feels that it was time to recognize the utter neglect of primary care and primary healthcare institutions.

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\textsuperscript{22} Asha Krishnakumar “health and medical care in Chennai” “A gateway to health”. The journal of front line. Vol 20 no 11 May 24- June 6,2003p.110


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**Nandraj and Duggal**\(^{25}\) in their study on physical standards in the private health sector, are of the opinion that the unregulated, unreliable quality of healthcare. The study was undertaken to identify the nature of care available to people in the private sector resulted in a situation of poor and unreliable quality of healthcare. The study was undertaken to identify the nature of are available to people in the private health sectors in Satara district in Maharashtra. They bring into focus the poor implementation of existing about reforms in this sector. They feel that minimum standards and requirement of various kinds of hospitals should be laid down and be made legally binding by the government.

**Sharma and Chaha**\(^{26}\) have made a study on patient satisfaction in outdoor services of private healthcare facilities. They feel that the concept of patient satisfaction encouraged the adoption of marketing culture in service sector including healthcare services and pointed out that the strategy for patient satisfaction in healthcare services requires effective marketing plans, policies and practices to genuinely meet the needs of different strata of population. They are of the opinion that the average degree of satisfaction secured by patients in the private healthcare sector is far greater than the degree of satisfaction secured by them from the government.

\(^{25}\) Nandraj S and Duggal R :physical standards in the private health sector, Radical journal of health new series vol II :2/3,April-septemper 1996 pp 141-186

health system. The study also highlights the factors responsible for overall patient satisfaction and suggested strategic actions for meeting the needs of the patients of private health sector more effectively.

Ramachandrudu and Venkata Rao\textsuperscript{27} examines the inter-district variations in health services in Andhra Pradesh. They point out that there are wide inter-district variations in the health infrastructure improvement. The more urbanized districts like, Hyderabad and Visakhapatnam have been doing the better than the districts with more rural populations. While analyzing the inter-district variations, they observe that the variation with regard to the hospitals and dispensaries was increasing whereas the variation in the number of beds available and the number of doctors is decreasing. The study concludes that the health infrastructure was closely related to the Couple Protection Rate (CPR) and hence it recommends that the variation in health infrastructure among districts had to be reduced for the success of family welfare programmes.

2.3 MANAGEMENT PROCESS AND POLICIES

This dimension addresses the patient’s experience with regard to the kind of care given by the doctors, nurses, paramedical and support staff, and administrative staffs in the hospital. Research done to study the quality of care given by health-service personnel has highlighted several dimensions. Administrative processes in a hospital set-up include the processes during admission, procedures during stay in hospital, and the procedures involved in the exit and discharge stage of the patient’s stay in hospital.

\textsuperscript{27} Ramachandrudu and Venkata Rao\textsuperscript{27} examine the inter-district variations in health services in Andhra Pradesh. Health planning in India -A P H publishing corporation New Delhi 1997 pp 67-70
The study on hospital administration with reference to Bombay’s Municipal hospitals by Aloo Noshir Dalal\(^28\), examines in detail the functioning of three major municipal teaching hospitals. The findings of the study revealed that training is noticeably absent. Absence of proper communication, between staff and patients, and also among different categories of staff, is leading to many problems in hospital administration. It is found that unionization has been regarded as an obstacle to effective hospital administration. The study suggests that it is the duty of the administrators to unite all the services and make the employees feel that their work and association within the hospital organization represent a vehicle that will accelerate the achievement of goals of the organization.

Atthreya\(^29\) in his study on inexpensive ways to improve hospital administration, points out that the demands on the hospitals are constantly increasing whereas the facilities remain stagnant or do not correspond to the increasing demands as they are starving for funds. He feels that the Central and state governments have not paid sufficient attention to the problems of health and have failed to evolve a comprehensive health scheme whereby even after 40 years a large majority of the people are not benefited by the medical care programmes initiated by the government. He is of the opinion that in present times, hospital administration cannot be neglected for several reasons and suggested measures to improve hospital administration within the available resources.

\(^28\) Aloo Noshir Dalal, Hospital Administration with reference to Bombay’s Municipal Hospitals, University of Bombay, ICSSR, July-Sept. 1987

Arun Bal\(^{30}\) made a study on Consumer Protection Act and Medical Profession. In his study, he discusses the validity and relevance of the objections and criticism made by the medical profession about the Consumer Protection Act. He is of the opinion that the Consumer Protection Act provided a civilized outlet for the discontent amongst the consumers of health, but at the same time it also generated intense controversy in the healthcare field. He feels that apathy; indifference of members of profession towards ethical standards and absence of self-regulation caused damage to the reputation and credibility of the medical profession. Here Arun Bal discusses the provisions of Consumer Protection Act and highlighted its implications on the consumers of healthcare as well as the medical profession. He feels that in spite of the irrational and illogical arguments put forward in support of medical profession’s case perceiving Consumer Protection Act as a threat, it is necessary to rebut all these allegations and arguments in the long-term interest of the consumers.

Chhaparwal, Mishra and Chaskar\(^{31}\), in their study on Health Management Education, feel the need for health management education of high quality, capable of developing management skills and attitudes, which not only fulfill the necessary requirements but also go beyond it to bring about the requisite changes in the healthcare system. Since hospitals are increasingly becoming complex organizations and are becoming the hub of activities they have felt the need for hospital administration as an academic discipline in India, if it has to prosper and face the opportunities and challenges of healthcare. They are of the opinion that separate breed of healthcare administrations is the need of the Indian healthcare system to run

\(^{30}\) Arun Bal "Consumer Protection Act and Medical Profession", Economic and Political Weekly, March 13, 1993, pp.432-435

our healthcare system more effectively and efficiently to ensure good health to the large masses of India.

Chandrasekhar and Balaji Prasad\textsuperscript{32} in their study on health management, observe that health is a tool concept, which includes preventive, promotive, curative and rehabilitative. Health is the responsibility not only of the government, but also the private, non-governmental organizations and more so of every individual. They feel that healthcare management in India failed to create adequate health facilities in rural areas in spite of the increasing plan allocations. Growing inequalities in the quality of healthcare between private and government hospitals is the cause of concern. The cost of healthcare is increasing enormously. They suggest policy aspects like collection of user charges in government hospitals, promoting health insurance schemes and improving health information system, which were the top priorities for better health management system in India.

Diaz\textsuperscript{33} concluded from their study of passengers' reactions to delays in the airline industry that anger is the dominant emotional reaction to delays in service. In other words, in situation of negative result of a service where negligence in the productive process is attributed to the providers, the emotional reaction will not be one of simple dissatisfaction, probably anger will be shown. Anger, in place of satisfaction with service, is the main determining factor in propensity to complain, which would support Studer\textsuperscript{34} supported discharge phone calls and post-visit calls to patients because these calls accomplish several goals. Phone calls are found to


\textsuperscript{34}Studer, Q. (2003) How healthcare wins with consumers who want more. Frontiers of Health Services Management, 19, 4, 3-16.
demonstrate empathy and ensure that discharge instructions are being followed, provide an opportunity to learn about the patient’s perception of service, gather information to recognize staff, improve clinical outcomes and generate ideas for process improvement.

CONCLUSION

In the hospital sector, a clinical audit process is often adopted. Clinical audit is designed to measure the work of medical practitioners against agreed standards to ensure that professional aspects of patient care are constantly reviewed. Health care providers are now required to become more responsive to patients’ needs while working with a clearly established framework for determining clinical performance. A critical dimension of health-care quality is the experience of the patient with different processes that are a part of his/her stay in hospital. This dimension covers the clinical and administrative procedures and processes in the hospital. Lewis stated that a process refers to service delivery systems; the various physical features associated with an organization and are services, and the role of the organization’s employees (both customer contact and backroom staff) in the service encounter and the delivery of service quality.

2.4 DOCTOR’S SERVICES

Introduction

There has been an increasing tendency in recent times to apply marketing, business and consumerist models to the provision of care of modern medicine. This reflects changes in the way the health service is perceived both by the providers and the recipients of care. Along with these changes have come alterations in the

terminology employed by the health service and those observing it. Reflecting their training in business related disciplines; the administrators of the health service have led many of these changes as they oversee what has become an expensive and complex service. Although the provision of a more efficient and effective service is obviously laudable, we have noted that in using certain business related terminology the fundamental basis of the health service, the actual provision of health care to individuals and their relationship with their individual doctors, may be somewhat overlooked. A typical example is in referring to people as “clients” or “customers” of the doctor or hospital. Although it has been shown that people tend to vacillate between the “consumerist” and “passive patient” positions in their interactions with doctors, our results demonstrate that people still definitely view themselves as being in a relationship that is different to one of dependency or simply a business style terminology undermines and overlooks the complex process occurring when a stick person presents for treatment to their doctor. It is also demand efficiency and professionalism, if we continue to reduce the provision of health care to a service in which the stick represent merely the paying customers we certainly risk alienating a population who also expect a traditional caring attitude. Better understanding and communication are the goals that should guide the administrators of the service; the doctor’s rendering care and the patients attending in order to provide optimal care.

This dimension measures the patient’s experience in respect of the quality of care delivered by the doctors. The medical encounter provides an interesting opportunity to study service encounters. The encounter between a doctor and a patient requires intensive levels of interaction where the encounter has been shown to have a significant impact on patient satisfaction Chesanow, & O’Connor. These

interactions typically involve complex communication patterns and customer problems Bitner. There is often a formal, long-term relationship between doctor and patient, with the doctor having a significant discretion in meeting customer needs, and evaluation is largely based on credence attributes Bitner, Lovelock and Zeithaml.

Gwerwa found from patients and their families the important factors in their health-care experiences: having information, choice, participation, coordination of transitions, and knowing that preferences would be honored and respected. He found three of five factors affecting service quality perceptions of hospitals were related to the interactions with doctors or other staff. Two agreements have surfaced from the growing body of literature related to customer satisfaction and service quality. First, satisfaction and service quality are conceptually distinct but closely related constructs. Second, service quality is primarily a cognitive, left-brained, evaluative, objective concept, while satisfaction is combination of an affective, right-brained, feelings-based and subjective component, with a cognitive, left-brained, evaluative and objective component. The affective component of satisfaction is expected to be salient, especially in the domain of physician services. These factors included professional expertise, validation of patient beliefs, interactive communication, image and antithetical performance.

Physician services are high in credence properties and there is so much at stake that the patient is unlikely to feel happy unless he/she establishes an

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emotional bond with the doctor Shemwell. This is particularly true in developing
countries where social interactions and personal connectivity (high touch) are very
important. Malhotra. The patient-doctor relationship presents a framework for
studying relational exchanges. Ongoing doctor-patient relationships place more
emphasis on feelings and emotions rather than cognitive elements, as would be the
case in an analysis of a discrete exchange.

Carman stated that acute hospital services provide a salient setting to
study the Gronroos dichotomy between the affective attributes of the service
experience and the technical attributes of outcomes of physician care. In the
measurement of past patient perceptions of quality and satisfaction, hospitals have
been criticized for focusing too much on the “hotel accommodation” dimensions of
the stay such as food, noise, room temperature and cleanliness rather than on the
outcome of the illness episode.

an empirical test of a model of service quality, satisfaction and relationship-oriented

41 Malhotra, N. Marketing Research, Fourth Edition, Pearson Education, India,
Health Management, 1, 261-275.

Journal of Services Marketing, 14,4,337-352

M.A.,
2.5 NURSING SERVICES

Introduction

The dimension on nursing-care quality assesses the perception of the patient with respect to the quality of nursing-care provided during his/her stay in the hospital. Nursing service is one of the most important components of hospital services. Nurses form the single largest technical group of personnel engaged in patient care, in hospitals next to doctors, accounting for approximately one-third of hospital costs. Researchers have made important discoveries about the relationship between nursing and patient outcomes. These studies have highlighted the vital contribution of nurses to the quality of patient care. Nursing care is extremely important for good patient outcome. While physicians plan the treatment and perform the diagnostic and treatment procedures, it is the nurses who spend more timing caring for the patient and looking after all his needs throughout the hospital stay. The success of the patient care and the reputation of the hospital demand to a large extant on the efficiency and the tender loving care extended by the nursing staff. Ensuring high level of nursing care is, therefore a big challenge for the Hospital Administrator. Nurses constitutes a large proportion of the total number employees in any hospital. Nursing is the single largest department of the hospital. Further, due to the close work relationship with ward support staff, generally the Nursing service also manages ward clerks, medical orderlies, porters and sometimes, even cleaners and other housekeeping staff. The sheer magnitude of nursing department necessitates strict compliance with the conventional principles of organizational structure and function. Fortunately, this is not a problem in most hospitals.
Carman\textsuperscript{44} used a regression model in which the quality of a set of attribute dimensions are rated and regressed on a rating of overall quality, and reported that nursing care was the most important attribute of acute hospital care. In another study by Carman\textsuperscript{45} once again, nursing care, as the core service of hospitals, was consistently rated as the most important. The other technical attributes of hospital services, namely, the outcome of the hospitalization and physician care, were rated the second and third important attributes.

2.6 PARAMEDICAL AND SUPPORT STAFF QUALITY

Patient perception of the quality of care, attention, empathy and skill of the paramedical and support staff in the hospital is examined under this dimension. A number of recent studies have helped us to learn more about patient evaluation of medical encounters Andaleeb\textsuperscript{46}, Proctor and Wright\textsuperscript{47} These studies have underscored the importance of the service encountered (i.e. the interactive component of service provision) in determining overall satisfaction.

Andaleeb\textsuperscript{48} found that three out of the five factors leading to customer satisfaction with hospitals had to do with patient-staff interaction (e.g.

\begin{thebibliography}{99}


\bibitem{48} Andaleeb ibid

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communication of hospital staff with patients, competence of the staff, and staff demeanor. In a study in a related sector, Lewis⁴⁹ (in a study of customers of banks, retail outlets and building societies) found that customers rated the four elements of reliability (accuracy of transactions, ability to do things right, ability to keep promises, and competence of backroom staff) as very important and very satisfactory. Retail consumers gave higher ratings to politeness, friendliness, helpfulness, the respect and consideration shown by staff, and individualized attention given. Bank and building society respondents attached more importance to staff knowing personal needs, confidentiality and discretion.

The quality of communication that the patient has with the personnel in the hospital has an important bearing on the patient’s perception of quality of care. Several studies have examined the importance of communication in the service interaction. Curry and Sinclair⁵⁰ used SERVQUAL to improve patient satisfaction by enhancing communication with patients and increasing their access to information relating to their condition and its treatment.

Frohna⁵¹ stated that promoting health and alleviating illness and suffering are the essence of doctoring and the focus of the physician-patient relationship. Regardless of whether a patient is cured, the outcome of the physician-patient encounter depends on communication. Through effective communication, physicians are more likely to positively influence health outcomes for their patients. He elaborated that effective physician-patient communication is recognized as an


essential skill for physicians in practice. Physicians should be aware that communication with patients is a complex process and keep in mind principles that contribute to the overall outcome of physician-patient communication. Bensing\textsuperscript{51} declared that communication is the pathway to medicine that is patient-oriented instead of disease-oriented. The study revealed that to be effective, communication must be a two-way process—both physician and patient need to offer and accept information.

The study by Frohna\textsuperscript{53} noted that non-verbal cues can speak as powerfully as verbal cues. Aspects of non-verbal communication include body language, proper use of space, Para-language and touching. The study outlined two modes of communication, a traditional authoritative approach and a collaborative approach. The authors of the study recommended a collaborative style of communication to allow physicians to sustain mutually respectful relationships with their patients. Stein\textsuperscript{54} conducted a longitudinal study of a large health-care organization, with the aim of enhancing the clinical communication and relationship skills of the clinicians. The study notes that enhancing clinicians’ communication with patients is a complex task requiring planning and organizational commitment.

\textsuperscript{53} Frohna, ibid
Kerzman\textsuperscript{55} aimed to assess patients reported as opposed to correct knowledge about medication after discharge from hospital and to identify factors that increased correct knowledge. Most patients were found to be aware of the course and purpose of their medication. However, they were reposted to be unaware of the side effects, needed lifestyle changes, and correct medication schedules. A large difference was found between levels of reported and correct knowledge about various issues regarding medication. The factor which significantly affected levels of correct knowledge was whether the patient had received medication counseling during hospitalization. The study indicated the need for patient counseling during hospitalization, with respect to medication therapy. Graugaard\textsuperscript{56} examined the changes in physician-patient communication over time. Consultations were found to be generally physician dominated and task-focused. While the amount of task-focused communication was significantly reduced between the initial and the return visits, the amount of socio-emotional communication remained quite stable. In return visits, patients with more severe diagnoses were given longer consultations and they provided more task-focused information to a less verbally dominant physician. Patients were found to be more satisfied in the second and return visits (but not in the first), if consultations contained greater levels of socio-emotional communication.

Mahajan P. Mani\textsuperscript{57} The primary responsibility of the medical social worker is to assist the patients and their family with those social, environmental, economic or psychological needs which may affect their uniting to adjust to their


\textsuperscript{57} Mahajan P. Mani "helping patients in hospital" the joined of social welfare, Vol XXXIII No 9, 1986 pp.4-5
illness or their optimum use of medical care. The medical social worker makes use of his/her special knowledge and skill in understanding and helping patients; this is done by developing a sound relationship with the patients so that they can share their difficulties with the social worker and tackle the problems created by illness with her/his help and encouragement.

**Jha S.M**\(^{58}\). It is right to mention that in addition to proper medical aid, they need love and affection which would be a right course of treatment. The doctors, nurses, sisters and other personal are required to play an important role in order that the addicted persons make a gaud bye to their habits and start a new life and a new chapter.

In conclusion, therefore, although ongoing improvements and changes in the provision of effective health care are necessary the use of some long established and accepted ideas and terms in the community such as patient should be continued in the modern health care service.

### 2.7 SUPPLY MANAGEMENT

**Padmanabhan**\(^{59}\) in his study on the Health Sector, points out that one of the major tasks in the country in the new millennium was meeting the challenges of health. He feels that there has been a significant gap between the demand and supply in terms of health institutions, drug supply and availability of paramedical staff. He stresses the need to enhance the plan outlay for health sector, ensure its equitable distribution between states, narrow the rural urban gap and create the required infrastructure for effective health services. He feels that increase in population by


\(^{59}\) Padmanabhan B.S., "Meeting the Challenges of Health," Yojana, January 1999, pp.59-64
leaps and bounds is one of the main reasons for the inability of development initiatives, including community health programmes, to make visible impact.

**Broiler and Horn**⁶⁰ in their study on health and the Welfare of US Business, are of the opinion that the politicians and business leaders accepted the conventional wisdom that healthcare costs were largely responsible for US competitiveness problem and any efforts to control healthcare costs were unlikely to improve their competitive position. They feel that it was time to recognize the need for a new paradigm and to realize that, ultimately, controlling the cost healthcare requires immediate attention and priority. They suggest that companies must intervene in the supply side of the healthcare market just as they intervened with other key suppliers and also encourage employees to participate in decisions regarding healthcare delivery and educate employees about health management.

**Raju and Lonis**⁶¹ proposed a framework linking quality context, quality outcomes, market orientation, and market/product development outcomes to the financial performance of hospitals. The results supported a sequential chain of relationships among the constructs where market orientation mediated the effect of quality context on quality outcomes, and market/product development mediated the effect of quality outcomes on financial performance of the hospital.

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