Chapter- 1

Introduction

1.1 Prologue of Research

Recent globalization of our terrestrial planet has given a facelift to India by injecting new plans, policies and causing overall development in different fields of India. The market has now become fully globalized and alarmingly competitive. It has become mandatory for each business to be ahead in competition, if it wants its head on its shoulders. It has now been well established that it is not the complication and uniqueness of any business or industrial plan but it is the provision of classic service quality that carves any success story. Service quality is the solemn factor which if managed according to the need of the hour, brings customer satisfaction from present clients and pours tones of new clientele. It is the crux of all successes, hence should be met with and kept alive under all circumstances. Service quality may be the deciding factor responsible for decline and further disappearance of any business or service organization.

Now-a-days almost all service organizations are undertaking reforms to enhance and improve the quality of service they provide. As the irrefutable cause of success of any service providing firm is closely intervened with the quality of service publicized and rendered by them. If the quality of service is skillfully looked after and consistently maintained in an inimitable way then such service organization can gradually conglomerate other service with it, expanding its wings and wealth. An important aspect or service industry is to make their customers satisfied. To meet this need of the hour, the significance of adding service quality practices has become the call of the hour. Acceleration of living standards and zillions of livelihood earning options are progressing the modern society towards better quality of life with lavish lifestyle characteristics. Hence, the latest fad is experimenting and using good quality of services even at the cost of a king’s ransom. People just want to explore the experience of having and living the best quality of services. This has intensified the most frequently encountered problem in the service industry that is maintaining the satisfaction level of the customer to retain the intoxicated clients.
Researchers have extrapolated that a mosaic of attractive, additional and discounted facilities play an praiseworthy role in capturing and holding the customers with high potential and hefty bank balances. Hence, now a business is not a single entity but a beautiful conglomeration of various other sectors and helper business of the society. In hospital industry, majority patients spend days to weeks, for any treatment so it is compulsory for the industry to pay heed to their comfortable stay; hence in this single business various facilities play a major role in customer’s satisfaction. The service quality of any organization is not only measured by the profitable sales of the organization, but also by and large depends on the satisfaction level of their customers.

1.2 Origin of Service Quality

Service quality is a term which describes a comparison of expectations with performance. Receiving a high level of service is important to consumers but understanding how to evaluate the service quality received is more difficult. Service qualities include such items as color, style, fit, feel, smell, and price. Consumer goods such as shoes, jeans, refrigerators and lawn mowers are high in search qualities. Business goods such as raw materials, component parts and office supplies also tend to be high in search qualities. Because these goods are high in search qualities, consumers can easily evaluate the quality of goods prior to purchase.

Service quality is a combination of two words, service and quality where we find emphasis on the availability of quality services to the ultimate users. The term quality focuses on standard of specification that a service generating organization promises, scientific inventions and innovations makes the ways for generation of quality. The service quality satisfaction is the outcome of the resources and activities expanded to offer service against the expectations of users from the same. The technical measures draw our attention on the inventions and innovations in the field of technologies that help to improve the quality of services. The functional measures gravitate our attention on improving the quality of services offered by the employees, which pave ways for style of functioning, work culture. the frequency in the process of technological innovation vis-à-vis the growing influences of high-performer employees develop technology-driven and user friendly service with a new quality. The functional quality of employees can be improved by strong emphasis on behavioral, inter- personal relations, appearance, commitment. It is right to say that
poor quality of services or service failures are not designed into the system by the choice of senior management.

Quality is defined as the ability of service provider to satisfy customer needs. Customer perception, service quality and profitability are interdependent variables.

The five determinants on the basis of which service quality is measured are:-

- **Tangibility**: it includes the service provider’s physical facilities, their equipment and the appearance of employees.

- **Reliability**: it is the ability of the service firm to perform the service promised dependably and accurately.

- **Empathy**: it is the caring, individualized attention the service firm provides each customer.

- **Assurance**: Assurance refers to the intelligence and behaviour of the company’s staff and their skills to instill faith and loyalty in the customer.

- **Responsiveness**: it is the willingness of the firm’s staff to help customers and to provide them with prompt service.

### 1.3 Service Quality: Concept

Service is the bicycle of market, having wheels named give and take; i.e. fulfill some one’s need and take currency in return. Service is a virtual feature; it can only be experienced, remembered or forgotten but can never be touched or seen. Various kinds and categories of services offered by service providers cannot be seen & touched, as they are intangible activities.

Some basic definitions of Service Quality are as follows:

“A service is any activity or benefit that one party can offer to another which is essentially intangible and does not result in the ownership of anything.” **By Kotler, Armstrong, Saunders and Wong**

“Services are economic activities that create value and provide benefits for customers at specific times and places as a result of bringing about a desired change in or on behalf of the recipient of the service.” **By Christopher Lovelock**
“Services are the production of essentially intangible benefits and experience, either alone or as part of a tangible product through some form of exchange, with the intention of satisfying the needs, wants and desires of the consumers.” By C. Bhattachargee.

The basic difference between service & product is that services are intangible but products are tangible and are required to follow some standardized procedures. Service user can specify about that particular service satisfaction only after availing it for some period of time. Some of the common service areas are: Retailing, Transportation, Cell phones, Education, Health & hospitality Services, BPO and many more.

1.4 Importance of Service Quality

The controversial issue of customer satisfaction can no longer be fudged or dodged. This intricate issue if not sensibly dealt with may become intractable. Current competitive environment induced by downpour of globalization and advances in information technology have inducted the companies to focus on managing customer relationships, and in particular customer satisfaction and customer loyalty in order to efficiently maximize revenues. In the age of customer delivering quality service, it is considered an essential strategy for success and survival in today's competitive environment. The focus of any supply chain management system is to provide all customers with the level of service they require and as each budget has a dead end, there is need to prioritize services and work intelligently towards them.

Benefits of high quality customer service:

- Enhanced customer satisfaction
- Stronger customer loyalty
- Equanimity of work-flow practices
- Decelerating marketing costs
- Competitive advantage
- Improved market position
- Staff pride and satisfaction.

Customer service sometimes is the deciding criteria of a business from its other market counterparts. It involves many aspects of business operations, including:
• Diluting details about products and services
• Counter and face-to-face service
• Telephone service
• Taking customer orders
• Follow-up documentation
• Billing and managing payments
• Visiting the customer
• Making repairs
• Handling complaints
• Managing the service culture.

1.5 Scope of the Service Quality

The “Scope of the Service in terms of Quality is the most important parameter in terms of Production cost”. Hence, appropriate customer management system must always remain functional to pour in Service Requirements according to the actual Business needs (not only in Quality but also in terms of Budget). For example, sometimes increasing Availability from 99.2% to 99.7% carries a cost which might not be justified in terms of Business Value.

Quality is a manufacturing parameter and is impossible to set it into a fixed frame as it is ever-changing, immeasurable and person specific. Although, “picking up the concept of deviation from specifications, one could see it as a measure of deviations from service parameters and stakeholders expectations”. Quality is a descriptive literary concept and is effortless to quantify it. When it is summed up with the
dimension of stakeholder’s expectations to measure service quality then it becomes an intangible feature.

1.6 Service Quality Model / GAP model

There can never be an accurate and precise definition of high quality. It has different meanings. Heights and parameters in different circumstances. The GAP model of customer satisfaction was proposed by V.A. Zenithmal et.al. The model is a thoroughbred expression of service quality delivery gaps or deficiencies occurring in a business or within an organization, that restrict the delivery of high-quality service to customers. It has been recognized that satisfaction is incontrovertible and is faithfully linked to quality perception. These gaps are discussed as:-

GAP 1:- Not properly understanding customer’s needs.

This type of gap occurs twixt the quality of service expected by the client and the company’s perceptions. Expected service is the utmost grade of desired service dreamt of by the customers. A company’s perception of consumer expectations is its knowledge about customers requirements. Such type of gaps indicates the company’s inefficiency to read consumer minds and accurately interpret their expectations.

GAP 2:- Improper skill in setting right type of standards.

Many a time’s the customer’s service standard expectations may be either more or less than the standards set by the service providing organization. Main reasons causing this kind of gap are: lack of customer driven standards of service delivery, nugatory quality control goals, false or incorrect service design.

GAP 3:- Not behaving according to service standards.

From each dawn to dusk, it is the most frequently encountered failure and is caused by problems occurring during service delivery. The general features indicative of this failure are: short supply of right type of employees or their faulty training in service delivery, absence of workers empowerment, incomplete training of the franchisee’s staff, failure to predict scrupulous amount of goods needed, incompetence in matching supply and demand fluctuations, and insufficient customer education.
GAP 4:- Failure to meet the promises in performance.

Most men we meet are bloke of words only a few of them are hombre of deeds. All businesses circulate heaps of promises in the market in order to attract and win over customer. But concrete truth is that all promises are hard to keep and still harder to achieve, most of the times due to financial limitations and sometimes due to physical barriers. This becomes the main cause of customer disappointment and ultimately clientele loss. The primary reasons for this kind of breakdown are vague communication with customer, heavenly promises through advertisement or personal selling, absence of internal communications.

GAP 5:- Gap between expected service and experienced service.

This gap arises when the customer has an over-rated imaginative service quality and when he actually experiences depleted and deprived version of it. This gap can arise due to insufficient research and development programs conducted by the organization, and misleading understanding of customer’s expectations.

1.7 Service Quality of Health Care Industry in India

Reported records from the past, from both assembling and administrations commercial enterprises talk that "quality is the life determinant of piece of the pie and rate of return and also cost decrease" (Anderson and Zeithaml 1984; Parasuraman et al. 1985). Two sorts of value are noteworthy for administration giving associations: specialized quality and utilitarian quality (Gronroos 1984). In the human services industry, specialized quality setting is basically alluded to as quality and it is ascertained and confirmed on the aftereffects of the specialized exactness of the judgments and methods. Multidimensional strategies for bookkeeping specialized quality have been proposed and are presently experienced in medicinal services associations (Joint Commission for Accreditation of Human services Associations 1987). Be that as it may, this data is not weakened to the outside open consequently, "information of the specialized incredibleness of social insurance administrations stays inside of the domain of medicinal services experts and chairmen" (Bopp 1990).

Utilitarian quality reaches out to the different courses in which the human services administration is given to the patient. As not in normal condition and appropriate psychological well-being to accurately judge the specialized angle and administration gave to them, utilitarian quality is typically the essential component of patients'
quality observations (Donabedian 1980, 1982; Kovner and Smits 1978). The realities represent themselves this apparent quality is the fabric highlight impacting shoppers' worth recognitions. These worth discernments, thus, get to be tidbit components choosing buy of items or administrations (Bolton and Drew 1988; Zeithaml 1988).

**Service:** We all need to accept that the distinction between goods and services is fiendish and opaque. Despite this delicate line, the following felicitous definition provides the base point to develop an understanding of the differences between goods and services. In general, “goods can be defined as objects, devices, or things, whereas services can be defined as deeds, efforts, or performances”. Service has been defined as “a social act that occurs directly between the consumer and representatives of the service corporation”. Service includes everything- an easy task as listening to a complaint or a complicated one like building a multi-storey apartment. Many organizations like-“education, banking, insurance, defense, municipal services, welfare services, legal services, health services and so on are purely service business, their products being intangible”. The companies have now switched their competitive focus to “the provision of unmatched & unparalleled customer services”.

**Quality:** When the expression “Quality” is used, the picture that comes to our mind is of a premium, classic, “ultimate product or service that fulfills or exceeds our expectations. These expectations are based on the intended use and the selling price. Products are determined by its quality. Quality can be quantified as Q = P/E. Where Q = quality, P = performance and E = expectations. Quality is a complex phenomenon based on ferocious perceptions by individuals with different outlooks on products and services. These perceptions have been built up through the past experience of individuals and consumption in various contexts”.

**1.8 Customer Satisfaction: Concept**

Consumer loyalty is 'girl next door' term of marketing. It is a measure of how items and administrations supplied by an organization meet, fall behind or surpass client desire. Consumer loyalty is characterized as "the quantity of clients, or rate of aggregate clients, whose reported involvement with a firm, its items, or its administrations (evaluations) surpasses determined fulfillment objectives." It is seen as a key execution marker inside of business and is frequently part of a Balanced Scorecard. In an ever-changing, extremely unpredictable competitive marketplace
where businesses compete for customers, customer satisfaction is seen as a key differentiator and increasingly has become a key element of business strategy.

"Within organizations, customer satisfaction ratings can have powerful effects. They focus employees on the importance of fulfilling customers’ expectations. Furthermore, when these ratings dip, they warn of problems that can affect sales and profitability. These metrics quantify an important dynamic. When a brand has loyal customers, it gains positive word-of-mouth marketing, which is both free and highly effective.

1.9 Importance of Customer Satisfaction

Customer loyalty is much harder to obtain than satisfaction. Even though customers are satisfied with the company there are several factors that could cause the customer to defect to the competition, such as finding a better value or the competitor is more convenient having high levels of customer satisfaction does not always lead to customer loyalty. However, a company cannot achieve customer loyalty without having customer satisfaction.

Customer satisfaction is a marketing term that measures how products or services supplied by a company meet or surpass a customer’s expectation. Customer satisfaction is important because it provides marketers and business owners with a metric that they can use to manage and improve their businesses.

Importance of Customer Satisfaction:

- It’s a leading indicator of consumer repurchase intentions and loyalty
- It’s a point of differentiation
- It reduces customer churn
- It increases customer lifetime value
- It reduces negative word of mouth
- It’s cheaper to retain customers than acquire new ones

1.10 Customer Satisfaction in Health Care Industry

Patients/customers, in their day-to-day life, experience varied kinds of medical care and services and accordingly frame their opinion about standards of services delivered to them (Choi et al., 2004). The service quality has two measurements "(an) a specialized measurement i.e., the center administration gave and (b) a procedure/practical measurement i.e., how the administration is given" (Grönroos
Parasuraman, et al (1988) developed a valuable device which has now turned into a broadly utilized model known as SERVQUAL for assessing the prevalence of the administration quality. In the SERVQUAL model, Parasuraman et. al. "recognized the hole between the discernment and desire of shoppers on the premise of five traits viz. unwavering quality, responsiveness, confirmation, compassion and tangibles to gauge shopper fulfillment in the light of administration quality (Parasuraman A., Berry L,1988)". Frequently, the parameter to judge the nature of the human services administration are fed by patient fulfillment reviews (Lin and Kelly 1995). Much confirmation has been recorded for the administration quality to fulfillment join in various shopper fulfillment thinks about incorporating those in the region of medicinal services promoting (Brady and Robertson 2001; Gotlieb, Grewal, and Cocoa 1994; Rust and Oliver 1994; Andaleeb 2001).

According to Shi and Singh (2005), from a patient’s valiant point the coin of quality has two faces “first face- quality as an indicator of satisfaction that depends on individual’s experiences about some attributes of medical service viz. comfort, dignity, privacy, security, degree of independence, decision making autonomy and attention to personal preferences and second fcae quality as an indicator of overall satisfaction of individuals with life as well as self-perceptions of health after some medical intervention” (Shi & Singh, 2005). These two faces of quality are always required at every step at every point to fulfill the its identity. These two elements when present in correct amount will provoke the feeling of fulfillment and sense of worth (Shi and Singh, 2005).

The patient’s happiness and contentment is watered three primary aspects of health care system. These are –“perception of patients regarding quality health care service, good health care providers and good health care organization” (Safavi, 2006). A study conducted by Safavi (2006) has revealed that “satisfaction with hospital experience was driven by dignity and respect, speed and efficiency, comfort, information and communication and emotional support”. A yearlong study completed somewhere around 2004 and 2005, a center gathering meeting was directed by the Office of Social insurance Exploration and Quality and Habitats for Medicare and Medicaid Administrations (CMS) to discover how patients see the nature of medicinal services. Finishes of this study unveil that that patients, generally, favored four characteristics of social insurance administrations viz. "specialist correspondence aptitude,
responsiveness of healing facility staff, solace and cleanliness of the clinic environment and correspondence of nursing staff" (Safavi, 2006). By and large, patients characterize nature of wellbeing administration more on the premise of qualities viz. admiration and empathy than specialized capability of specialists and staff (Safavi, 2006).

All the aforementioned techniques of measuring patient satisfaction indicate one thing that service quality is the ultimate thing regarding heart-thrilling contentment of patients. Regarding service quality, the two basic aspects are technical and functional. According to Kang and James (2004), “it is very difficult for a patient to understand the technicalities of treatment and hospital services”. Thus, present analyst has paid regard to the utilitarian parts of social insurance administration. To make this idea straightforward useful part of human services can be extended into procedure related and also practical. Practical quality can be characterized as the method for conveying human services administration to the patient. Babakus and Mangold (1992) pointed out that “SERVQUAL is designed to measure functional quality only. In the health care sector, functional quality depends on technical aspects which represent accurate diagnosis and procedure of treatment”.

1.11 Hospital Sector: An Overview

A hospital is a home away from home where you par for your health and happiness. It is the place that takes away your illnesses, ailments, diseases and pains of course!! Along with your bank balance. Along these lines, a hospital is a social insurance establishment giving patient treatment with three S’s :- skilled professionals, serviceable staff and safe equipments. Most common types of basic hospitals generally found everywhere are the general hospitals, which have an additional emergency department. A district hospital is the elementary health care facility in its region, with large numbers of beds for intensive care and long-term care. There are other categories of specialized hospitals that include - trauma centers, hospitals for children and senior citizens (geriatric) hospitals, and hospitals for dealing with specific medical needs such as psychiatric problems (see psychiatric) and certain disease categories. Specialized hospitals can play a significant role in reducing health care costs compared to general hospitals as they are specific in their knowledge of the disease and its treatment.
A teaching hospital comprises treatment of people combined with teaching to medical students and nurses, where the patients unknowingly become study related volunteers and raw materials for live experimentation. The medical facility in smaller area with limited facilities is known as a clinic. Hospitals constitute of a rainbow of “departments (e.g., surgery, and urgent care) and specialist units such as cardiology. Some hospitals have outpatient departments and some have chronic treatment units. Common helping hands include units of pharmacy, pathology, investigative laboratory and radiology”.

The treasure-trove of hospitals are poured in by- “health organizations (for profit or nonprofit), by health insurance companies, or by charities, including direct charitable donations. Historically, hospitals were often founded and funded by religious orders or charitable individuals and leaders”.[1]

Today’s hospitals are embellished with professional “physicians, highly qualified surgeons, and trained nurses” who pose as statutes of kindness and service; other flowers and leaves of the kitty are managerial staff, class fourth helpers, drivers, watchmen, security guards and miscellaneous domestic helpers. In good olden days, this task was looked after by high-class holy dignitaries or by self-service providers. Even today, there are some Catholic religious orders, such as “the Alexians and the Bon Secours Sisters that still focus on hospital ministry today, as well as several other Christian denominations, including the Methodists and Lutherans, which run hospitals”. [2] Exemplifying its actual meaning the word – hospital, hospitals were originally "places of hospitality", and the essence of this term is still alive facing the storms and sand dunes of times, in the names of some institutions such as – “the Royal Hospital Chelsea, established in 1681 as a retirement and nursing home for veteran soldiers”.

Etymology:

During the Middle Ages hospitals rendered services of all descriptions. They were alms houses for the poor, hostels for pilgrims and hospital schools. The word hospital comes from the Latin “hospes”, signifying a stranger or foreigner, hence a guest. Another noun derived from this- “hospitium came to signify hospitality, that is the relation between guest and shelter provider, hospitality, friendliness, and
hospitable reception. By metonymy the Latin word then came to mean a guest-chamber, guest's lodging, and an inn”.

‘Hospes’ is thus the – “root for the English words host (where the p was dropped for convenience of pronunciation) hospitality, hospice, hostel and hotel. The latter modern word derives from Latin via the ancient French romance word hostel, which developed a silent s, which letter was eventually removed from the word, the loss of which is signified by a circumflex in the modern French word hôtel. The German word 'Spital' shares similar roots”.

Spelling, writing pattern and grammar of this simple word differs interestingly depending on the dialect. In United States of America, “hospital usually requires an article; in Britain and elsewhere, the word normally is used without an article when it is the object of a preposition and when referring to a patient ("in/to the hospital" vs. "in/to hospital"); in Canada, both uses are found”.

**Types of Hospitals:**

Type of hospital primarily depends on the type of type of its customers. Some patients with milder form of diseases or bodily discomforts visit a hospital “just for diagnosis, treatment, or therapy and then leave ('outpatients') without overnight stay; while others are 'admitted' and stay overnight or for several days or weeks or months ('inpatients')”. Hospitals differ from other types of medical facilities and can be distinguished and categorized on the basis of “their ability to admit and care for inpatients whilst the others often are described as clinics”.

**General:**

The frequently talked off, well-known type of hospital is the general hospital. It deals with multitudunial classes of disease and injury, and is always equipped with an emergency unit to handle accidental, immediate-care needing and life-threatening cases. Larger cities have a mosaic of hospitals in all lengths and breadths. Now in India, many hospitals have their own ambulance service.

**District**

A “district hospital is the major crux of health care facility of that region”. Besides, providing all basic necessitous services and elementary emergency help it is loaded with large numbers of beds for intensive care and long-term hospital stay.
In California, "District hospital" is uniformly defined as a class of healthcare facility created shortly after World War II to meet the shortage of hospital beds in surrounding areas then witnessing wailing humanity. Even today, District hospitals are the solemn, faithful public hospitals in 19 of California's countries. Californian District hospitals are “framed and run by local municipalities, have Boards that are individually elected by their local communities, and are exclusively meant to serve local needs”. They are the home of hope and health to uninsured patients and patients with Medi-Cal (which is California's Medicaid program, serving low-income persons, some senior citizens, persons with disabilities, children in foster care, and pregnant women). In 2012, District hospitals provided $54 million in uncompensated care in California.

**Specialized:**

Various types of specialized hospitals comprise of trauma centers, rehabilitation hospitals, children's hospitals, seniors' (geriatric) hospitals, and hospitals for dealing with specialized medical needs such as psychiatric problems (see psychiatric hospital), certain disease categories such as cardiac, oncology, or orthopedic problems, and so forth. In “Germany specialized hospitals are called Fachkrankenhaus; an example is Fachkrankenhaus Coswig (thoracic surgery)”.

A hospital might contain a solitary, substantial building or a mosaic of dividers floor-rooftop blends in a grounds. Numerous doctor's facilities shelter over with time being as one working in pre-twentieth-century and advancing into grounds and colleges. A few clinics have held hands with colleges for restorative exploration and the preparation of medicinal faculty, for example, doctors and attendants, regularly called instructing doctor's facilities. All around, larger part healing centers keep running on a not-for-profit premise by governments or magnanimous trusts. There are however a couple of special cases, e.g. China, where government financing just constitutes 10% of pay of healing facilities. (need reference here. Chinese sources appear clashed about the for-benefit/non-benefit proportion of doctor's facilities in China)

Particular clinics are fit for decreasing annihilating human services expenses to resanoable consumptions, in contrast with general doctor's facilities. For instance, Narayana Hridayalaya's Bangalore cardiovascular unit, which is had practical experience in heart surgery, welcomes substantial bunches of patients broadly. It has
convenience of "3000 beds (more than 20 times the normal American doctor's facility) and in pediatric heart surgery alone, it performs 3000 heart operations every year" which is its remarkable element. Specialists there get a suitable, altered pay and thus are not paid for every individual operation. Therefore, as the quantity of strategies builds, the doctor's facility costs decelerate, exploiting economies of scale. Moreover, it gets reasonable that costs fall and come quite close to one and all, as every one of its pros get to be proficient by chipping away at one "generation line" strategy.

Teaching:
A teaching hospital is incomplete if standing alone, hence, it is always hand-in-glove with a medical school, nursing school or university and it combines assistance to people with teaching to medical students and nurses. Some countries like UK support-

The clinical attachment system that can be explained as- “a period of time when a doctor is attached to a named supervisor in a clinical unit, with the broad aims of observing clinical practice in the UK and the role of doctors and other healthcare professionals in the National Health Service (NHS)”.

Clinics:
The shops or chambers in concrete which provide ‘medical facility smaller than a hospital is called by the name clinic’. Mostly it is under supervision of a government agency for health services or sometimes a private partnership of physicians (in nations where private practice is allowed). Clinics generally cater to needs of only outpatients.

Departments or Wards:
Hospitals consist of very large spacious rooms or halls, traditionally called wards, especially when they have beds for inpatients, then they are sometimes also called inpatient wards. Hospitals generally have separate departments for acute services such as an emergency department or specialist trauma centre, unit, surgery, or urgent care.

These may then be supported by more specialist units such as the following:

- Emergency department
- Cardiology
- Intensive care unit
• Pediatric intensive care unit
• Neonatal intensive care unit
• Cardiovascular intensive care unit
• Neurology
• Oncology
• Obstetrics and gynecology, colloquially, maternity ward

The cherry on the cake is the department of nursing, under a visionary chief nursing officer or director of nursing. This department is headed with- “administration of professional nursing practice, research guidance and help, and policy making for the hospital”. Nursing is omnipresent in such institutions. Many wards support both a nursing and a medical director. For example, “in an intensive care nursery, the director of neonatology is responsible for the medical staff and medical care while the nursing manager/director for the intensive care nursery is responsible for all of the nurses and nursing care in that unit/ward”.

Many hospitals have “outpatient departments and some have chronic treatment units such as behavioral health services, dentistry, dermatology, psychiatric ward, rehabilitation services, and physical therapy”.

Common helping hands of a hospital are- “dispensary or pharmacy, pathology, and radiology. On the non-medical side, there are medical records departments, release of information departments, information management (aka IM, IT or IS), clinical engineering (aka biomed), facilities management, plant ops (operations, also known as maintenance), dining services, and security departments”.

The cancer of untouchibility that prevailed in our country in byzantine did not spare the health care services. Indian hospitals did not treated its kith and kin with uniformity but were demarcated on bases of caste and creed; mostly tuberculosis sanatoria.

Early Indian hospitals were mostly managed and operated under church’s observation, in a similar fashion as the Indian residential schools. The public health system in India comprises a set of state-owned health care facilities funded and controlled by the government of India. Some of these are controlled by agencies of the central government while some are controlled by the governments of the states of India. The governmental ministry which controls the central government interests in these
institutions is the Ministry of Health & Family Welfare. Governmental spending on health care in India is exclusively this system; hence most of the treatments in these institutions are either fully or partially subsidized.

Healthcare is one the fastest growing service sector in India. The healthcare sector as an industry is expanding rapidly and has not been as severely impacted by recent economic slowdown as some of the other industries. It comprises of hospital services, diagnostic services, diagnostic products, medical technology, clinical trial services and clinical research organizations.

1.12 History of Hospitals

A Health care institution well known as Hospitals provides treatment to the patients with the specialized equipments and staff. In ancient times the medicines were linked with the religion, the earliest institutions which aimed of providing treatments were historic Egyptian worship-places. In good-olden Greece, these worship-places were wholesomely and wholeheartedly meant for the God of Healing “Asclepius”, also called “Asclepieis” and these temples were functioning as the centre of medical advice. At these temples, patients were given “Enkoimesis” in place of “Anesthesia”, by a guidance of deity. These Asclepieis provided careful controlled healing spaces and use to fulfill the requirements of the institution created for the purpose of healing.

The worship of “Asclepius” was also adopted by the Romans. Under his Roman name “Esculapius”, the temple of this Roman god was provided for the healing of patients on an island in the Tiber in Roman, where the similar rites were performed.

The earliest present encyclopedia of medicine in Sanskrit is the “Carakasamhita”. According to this encyclopedia the hospital is found by “Dominik Wujastyk” of the University College London in the period between 100 BCE and CE 150. This text suggests that India may have been the first part of the world to have evolved and organized cosmopolitan system of institutionally based medical provision.

The hospitals evolution in west from “charitable guesthouses to centers of scientific excellence has been influenced by a number of cultural and social developments. These influences have included the changing meanings of religion, ethnicity, economics, disease, geographic location and the socio-economic status of the patients, technological and scientific growth and the perceived needs of the populations”.

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Chapter 1: Introduction
Indian Hospitals: Records of byzantine indications that fully workable and efficient hospitals possessed by India as early as 600 BC. During “the golden era of King Asoka (273-232 BC), Indian hospitals had the makeup of modern hospitals”. Providing healthy, germ free environment with excellent sanitation was the religion flowing in the air here. Complicated then and even now, cesarean sections were performed there with utmost care and high precision in order to save both fetus and female. Skilled and dedicated medical experts were appointed – one person for adjoining ten villages-to strictly supervise the health care needs of the salt of the earth, harboring there. Buddha never took the credit of establishing regional hospitals for the deprived, downtrodden and destitute.

The middle Ages: Religion has always been the cause of fever and faith in ambience of India. So it was a paramount factor regarding the concern for development of hospitals during the middle age. Hundreds of years between fourth century till almost all the fifteenth century, trade became diminished and thousands of city dwellers turned back to their rural, motherland pastures. Religious communities under their own priests and gods took over the responsibility for care of the sick. The humanitarian approach which was the jewel of Greek medicine during the era of Hippocrates died. The harmony and integrity vanished and hospitals did no longer remain medical institutions but were left a great deal to be desired. Just the miserable and desperate discovered their way to these healing centers. By now these health rendering and life saving temples had lost their soul. Then, the system there of categorical separation of patients on basis of their diseases became devastated, each hospital bed was made to be shared among three to five patients and sanitary esthetics were kept at bay. Surgery was wailed over because of visually impaired question on not to "exasperate the body" and to maintain a strategic distance from the shedding of blood per the congregation decree of 1163 that, as a result, precluded the church from performing operations. Only occasional amputation was permitted. However Religious order emphasizing nursing care came into being and “the first religious order devoted solely to nursing is considered to be the St Augustine nuns, organized in approximately 1155”.

Clinic development mushroomed in Europe amid the medieval times. There were two purposes for it. Firstly, Pope Blameless III in 1198 argued the proficient and rich Christians to construct healing facilities in each town in name of chapel and
philanthropy. Besides, expanded incomes could be reaped from this business with the crusaders. The most primitive healing facility as yet breathing are the "Inn –Dieu" in Lyons and Paris, France. As the name recommends "Lodging Dieu" shows that it is an open healing facility. The most punctual archived record of the Inn –Dieu in Lyons is protected in an original copy of 580 Advertisement, which declares that Childebert was its dad. The "Inn Dieu of Paris was established by Priest Landry in 660, on the LLê de la Refer to". In 1300, the healing facility had an incomparable, committed staff of doctors and specialists and the capacitious could then harbor 800-900 patients whenever, and this limit got multiplied in the fifteenth century. These clinics were less of pharmaceuticals and a greater amount of measures both medicinal and therapeutic. These clinics paid more notice to enhance mental and downright inside and outside wellbeing of the patient as opposed to just recommending chemicals to cure real sicknesses. The development of healing facilities quickened amid the campaigns, which started toward the end of the eleventh century. Plague and ailment were more intense adversaries than the Saracens in crushing the crusaders. Military doctor's facilities appeared along the voyaged courses: the knights Hospitalers of the Request of St John in 1099 built up in the Sacred Area, a healing facility that could watch over somewhere in the range of 2000 patients. It is said to have been particularly worried with eye illness and might have been the first of the specific healing facilities. This request has made due during that time as the St John's Emergency vehicle Corps.

Surprisingly, a counter effect was seen in Asia and Africa, and amid the same period, successful and effective healing facilities seeded by Islamic standard and the Campaigns and were sprouting here. Both the healing facility frameworks entirely fortified cleanliness measures, completed complex surgeries effortlessly and hand-picked patients as indicated by their ailment. The Islamic did as such on the grounds that they were all the while taking after the strides of the Greek and early Roman customs. What's more, the doctor's facilities made by the Crusaders conveyed it forward in light of the fact that wounds managed in battle called for surgery and the all inclusive event of nuisances and infectious illness basically squeezed out sterile conditions, strict partition and in some cases complete confinement of patients. First time ever in history of humanity, medicinal frameworks of the East and the West became hand and gloves to bow down in respect to supremacy of medical care. Arab
hospitals were the oasis in the desert for all and sundry as they had no demarcation between the blue blooded and the salt of the earth. They accepted, admitted and treated patients irrespective of their religious belief, race or social order.

**Renaissance Age:** The renaissance period marked its presence between the fourteenth to the sixteenth centuries. It was named after the Italian “rinascita” meaning rebirth. It is popularly believed that it was a journey back to home of the cultural believes of ancient Rome and Greece. The hospital again became healing centers of multicultural hombre. They again turned out to become sane and sanitized. During this period the secular authorities gave their support to these hospital saying that they were a kind of sacred institutions. Approaching the end of 15\(^{th}\) century small and big institutional healthcare centers had mushroomed in almost all cities and towns. It has been known that England alone supported more than 200 such establishments to meet the growing social needs of health and happiness. The steady transformation of healthcare responsibilities from the church to civil authorities did not stop in Europe after the dissolution of the monasteries in 1540 by Henry VIII, derailing hospital building in England for a stretch of almost two decades. Just the capable clinics in London survived when the residents requested of the Lord to invest St Bartholomew, St Thomas and St Mary of Bethlehem healing centers. It is the initially reported mishap of mainstream backing of healing centers.

The corruption of ascetic doctor's facilities in Britain engaged the common powers to take care of and medical caretaker the debilitated, the injured and the handicapped, thus seeds for the voluntary hospital movement was sown. The foremost voluntary hospital was born in England in 1718 by Huguenots from France, it started a trend and its footsteps were soon followed by such “London hospitals as the Westminster hospital in 1719, Guy’s hospital in 1724 and the London Hospital in 1740”. Time period lasting between 1736 and 1787 almost 18 cities outside London got blessed with such kind of hospitals. When this fruitful breeze blew towards Scotland it got its first intentional doctor's facility, the little Healing facility, which was opened in Edinburgh in 1729.

The renaissance age can be rightly called the time of the colossal institute of solution with the middle ages seeing the rise and downfall of majestic hospitals of its times. Schools of medicine rooted and flowered in Germany and in central and eastern Europe. The systematic, scientific study of human anatomy was simplified and
explained by dissections of animals. In 1506, a group called Royal College of Surgeons was organized in England, followed by organization of the Royal College of Physicians in 1528. The achievements in medicine for which the Renaissance age deserves a medal are: development of hospitals which were deep into helping out and curing the needy; upgraded management of hospital like clockwork; the trip back to home in taking care of the sick (the isolation of patients by malady) and procurement of the best nature of pharmaceutical accessible inside of the healing facility's limit divider. Clinical surgery had the best of the both universes amid this period, both in Italy and France. The uncrowned lord Ambrose Pare, created the most recent technique for using so as to cease discharge ligatures and abandoned the run down, debased arrangement of utilization of closing up irons. The kind air of northern Italy effortlessly processed these progressive thoughts. By the center fifteenth century, best specialists and finest doctors from all significant urban areas of Europe cleared their approach to Italy for cutting edge preparing and prepping and cleaning their claimed abilities.

**New World:** The pioneer healing centers of the New World were implicit provinces of Spain, France and Britain. Those worked under the banners of – "Catholic Spain and France held the standards of the Jesuits, the Sisters of Philanthropy and the Augustine Sisters" and tapped their full mental potential and mastery of healing facility learning earned by them after data of many years of diligent work. Healing facilities remaining in the premises of English settlements, rather conflicted with the wind and hailed their own particular characteristics.

The ever mentioned first healing center of the New World was developed as a major aspect of a framework for the control of abroad regions. Bartholomew de las Casas, one of the clerics who went with Columbus on his first voyage and a surely understood student of history alluded to the establishing of the town of La Isabella in Hispaniola(today, Santo Domingo), in January of 1494:" Columbus made flurry in building a house to keep supplies and the ammo for the troopers, a congregation and a clinic". No genuine records could ever be found to establish that whether this hospital was a dream or a reality.

Naming the foremost hospital of North America was built in Mexico City in 1524 by Cortes: its dignified architecture still stands true and proud. The French laid the foundation of a hospital in Canada in 1639 at Quebec City, the Hotel Dieu du
Precieux Sang, which is still in living and operating but has been dislocated from its original place. In 1644 Jeanne Mance, a French noblewoman, built a “hospital of ax-hewn logs on the island of Montreal; this was the beginning of the Hotel Dieu de St Joseph, out of which grew the order of the Sisters of St Joseph, now considered to be the oldest nursing group organized in North America”. The ancestral hospital in the boundaries of the modern United States was a serving center for soldiers on Manhattan Islands, established in 1663. At that point conceived, recently started doctor’s facilities were really almshouses, one of the apprentice of which was built up by William Penn in Philadelphia in 1713. The primary ever critical healing center of America was the Pennsylvania Clinic, in Philadelphia, which had the distinctions of having the sanction from the diadem (crown) in 1751. An engraving a wall of the institution states that it wanted that all its patients to keep their head held high and never lose their self respect at any cost thus removed any stigma from a hospital visit by charging fees. “Benjamin Franklin helped to design the hospital, which was built to provide a place for Philadelphia physicians to hospitalize their private patients. Franklin served as president from 1755 to 1757”.

An altogether different branch going in a different direction from the trunk was the “New York hospital that was founded in 1771 by private inhabitant individuals who first made a Society of the New York hospital” and could seek the permission to build it. The zest of learning and research always kept blowing in the hospital’s atmosphere. In contrast to other counterpart hospitals founded then the New York hospital was totally built out of contributions of wee traders and marginal husbandman (farmers).

The very thought of this is out of the world, but then came out of the paper and dreams, into concrete, the first hospital conducted, governed and managed by the fairer sex (women). It was named “The New York Infirmary for Women and Children was opened in 1853 by the first woman to earn a medical degree in the United States, Elizabeth Blackwell and her sister”. It is another example of a private enterprise that was founded to concentrate physician’s needs, and dilute methods of human health.

The European and Latin American tradition nurtured charity hospitals, who propagated that we should love God and look after our neighbors. Here the governments also displayed their moral imperative towards the penniless, helpless citizens. The US hospital did not owned a penny about these humanitarian principles. Along these lines, a more aggressive arrangement of doctor’s facilities created, with
fewer endowments and less inclusion of religious association’s altogether social insurance. In any case, cartloads of government impedance in social insurance segment started in 1926 with the arrival of veterans from World War I.

Ownership models

As has already been discussed that over the years between trees shedding their leaves and new leaflets emerging, different hospital models developed. Already named benefit and non benefit. Late groupings grade them into-revenue driven, private not-for-profit and open. Not at all like, have most different segments, revenue driven associations had their own particular space in United States and in all created nations supplying wellbeing administrations. In the US, such doctor's facilities constitute “15% of all nonfederal short term general hospitals in 1996(American Hospital Association 1998). By contrast, 59 percent of hospitals were private nonprofit and the rest were operated by government, primarily local governments or special government authorities”. Other mystified fact is that for profit hospitals market share grows slow and steady. Despite of the fact that for profit chains have grown in length, breadth, number and influence (since they first appeared in the late 1960’s), the share that small independents draw out of for profit hospitals has diminished.

A crisp study in India renders that medicinal services is conveyed by variegated open and private suppliers. The administration base is monster in both provincial and urban India. In towns, the "administration has a limitless base of essential human services focuses, group wellbeing focuses and sub focuses. The general population framework in urban India comprises of tertiary restorative schools, area and talk doctor's facilities and urban wellbeing posts". The private human services conveyance part contains a group of stars of "private specialists, revenue driven clinics and nursing homes and beneficent establishment. The normal size of such doctor's facilities is under 22 beds—much lower than created nations".

The essential goal of revenue driven, financial specialist claimed doctor's facilities were to animate the level of contributed primary sum. Prior specialists inferred that revenue driven doctor's facilities will probably be situated in more beneficial ranges and are littler yet progressed in offices, than philanthropic doctor's facilities. For benefit healing centers get less gifts in their kitty and are not charge sponsored, so their bread and butter is dependent on patient fees. On the opposite side “church
hospitals were owned and governed by religious organizations; they were originally organized to provide services for church members, to restrict procedures that are contrary to religious beliefs and to permit patients to follow the tenets of the religion for last rites and other ceremonies”. These doctor's facilities had confections in both hands with patient expenses and gifts. Government healing facilities are possessed and represented by governments, State or Central. “These hospitals rely on subsidies and grants for part of their operations and perform more charity than other hospitals. Because these hospitals are tax supported, government agencies are likely to monitor operations and have the authority to increase or decrease funding through budgeting processes”. Other philanthropic doctor's facilities have private proprietors and include fundamentally of group healing facilities or doctor bunch clinics. Physicians are the uncrowned kings here. These hospitals are fueled by payments made by patients and public donations.

Nonprofit firms are allowed to make profits by providing quality services. Truth be told, numerous, including healing facilities, do. In any case, philanthropic firms are prohibited from conveying its increases to its administrative group. Albeit such firms can make apparent installment in name of pay to its suppliers of inputs, yet coming about figures need not be dispersed. The firm has all rights to hold and utilize that sum. On account of the non circulation imperative, charitable of for-benefit versus philanthropic proprietorship, and private versus open proprietorship, has been the Throat cartilage for business analysts since decades. The very much confined, exceptionally worthy hypothesis predicts that the for-benefit hierarchical structure is sufficiently competent, as they get colossal motivating forces from the pedigreed and all around heeled furthermore appreciate lawfully enforceable property rights. Scientists investigating the impacts of:"revenue driven, private charitable and open clinic proprietorship on efficiency have reported an extensive variety of observational results". One school of scientists infer that the revenue driven structure accomplishes pounding, amazing beneficial productivity, while different studies review that for-benefit doctor's facilities face expanded expenses or markups than do charities. Clearly, an alternate class contends that charitable clinics have costs and/or quality like that of for benefits, inferring that possession status is immaterial in this connection and can't turn into a parameter for recognizing doctor's facilities.
In Indian scenario, the aforementioned conclusions prove their truthfulness and existence. There are hospitals both in the private and public sector whose service quality can better be experienced than inked. But this is only the brighter side of the picture. Behind the curtains, there are huge number of substandard quality healthcare services provided by rather dying hospitals, mostly on the shoulders of unskilled medical staff and diabolical facilities. Hence, here it could be rightly said that it is not the ownership model that gives its decision on the standard and working of any organization. But it would be sapient to account that—“the leadership and the resultant vision, mission and goals of the organization, is what determines the outcome and its quality in an organization”.

Albert Einstein said” We cannot solve operating problems by using the same kind of thinking we used when we created them,”

1.13  Hospital Industry and Its Services
Magnitude of healthcare industry is vast including a wide array of interconnected administrations which are identified with prosperity and flourishing of humanity. Human services is not individual but rather a social division and it is given and administered by State government with the assistance of Central Government. Health care industry is an integration of hospitals, dispensaries, health care centers, laboratories and diagnostic centers, also including “health insurances, medical software, health mending tools and medicines in it”.

Indisputably health care was present in the heart of human society since and even before the times of Ramayana and Mahabharata, but gradually with time, Health care sector has had a facelift from simple kitchen remedies to most complicated surgeries and organ donations. Improvements in Medical Science and technology have made it surpass all expectations.

The major ingredients of health care industries can be named as follows:
- “Hospitals”
- “Medical insurance”
- “Medical software”
- “Health equipments”

Social insurance administration is a mixture of substantial and immaterial viewpoints where the impalpable angle commands the elusive perspective. Maybe it can be
translated that most weight age here is ascribed by intangibility, as the administration’s (consultancy) offered by the specialist are totally impalpable. The substantial things could incorporate the bed, the style, and so forth. Endeavors made by clinics to tangibles the administration offering has been examined in point of interest in the extraordinary qualities part of the report.

Different types of health care services available in India:-

- “Hospitals”
- “Pathology Clinics”
- “Blood Banks”
- “Meditation Centers”
- “Emergency services like Ambulances, etc.”
- “Online Medical Services”
- “Telemedicine”
- “Naturopathy”
- “Yoga Centers”
- “Fitness Centers”
- “Laughter Clubs”
- “Health Spas”

The Constitution of India declares health as a state subject. Central government’s only interferes to assist the state government in needed areas of - “control and eradication of major communicable & non-communicable diseases, policy formulation, international health, medical & Para-medical education along with regulatory measures, drug control and prevention of food adulteration, besides activities concerning the containment of population growth including safe motherhood, child survival and immunization Program”. The plan outlay for central sector health programmed in the “Annual Plans 1997-98 was Rs.920.20 crore including a foreign aid component of Rs.400 Crore. A major portion of outlay was for the control and eradication of diseases like malaria, blindness etc. being implemented under centrally sponsored schemes”.

One more important segment concerning our health and well being, by the people in power is - “central health sector programmes with purely Central schemes through which fiscal assistance is given to institutions engaged in various health related
activities”. Such organizations are dedicated to varied fields for achievement of multitudinous objectives— in the field of control of transmittable and non-transferable sicknesses, medicinal instruction, training, research and pregnancy and post-natal care, child vaccination, child and parent-care.

**The Hospital Industry:-**

**Some Facts**

India's accessible human administrations industry has the estimation of Rs 73,000 crore just, which is a miniscule 4 percent of the Gross local item. The business is required to create at the rate of 13 percent for the cutting-edge six years which accounts an extension of Rs 9,000 crore consistently.

- The national typical of degree of family units in the inside and higher focus pay group has extended from 14% in 1990 to 20% in 1999.
- The people to bed extent in India are 1 bed for every 1000, in association with the WHO standard of 1 bed for each 300.
- In India, there exists space for 75000 to 100000 mending focus beds.
- Private security will drive the human administrations livelihoods. Considering the rising focus and higher focus pay group we get a preservationist assessment of 200 million insurable lives.
- Over the latest five years, there has been an attitudinal change amongst a section of Indians who are spending more on humans.

Corporate hospitals are ballooning since the late eighties. This deluge was just the bubble in the ocean waters and now out of the 22 listed hospitals, most are being blamed for dereliction of duty. Possible reasons for the derailment of these institutions from the derby are: despicable market economy, devious statistics, dicey capital intensive operations and a long gestation period. All these have named and made healthcare a dilapidated industry. Government and charitable hospitals are the uncrowned kings of this domain. But unskilled and disloyal management has led a disadvantage to many trust hospitals which have currently become a disaster to happen. Good corporate hospitals are still discordant and discredited by the salt of the earth.

Corporate hospitals lagged behind in the race a decade ago because they were naïve, emerged in isolation and departed from the general masses. Nonetheless, now, there
are the insurance agencies, the doctor’s facility equipment and the product
organizations that have held hands together as though their life relies on upon it.

Factors Attracting Corporate In the Healthcare Sector:-

“Recognition as an industry”: In “the mid 80’s, the healthcare sector was
recognized as an industry. Hence it became possible to get long term funding from the
Financial Institutions”. Thus the center loosened its rigid policies and also decreased
the import duty on medical equipment’s and technology, thus discharging this sector
from its clutches, allowing it to create its own sky and horizons.

Since the National Health Policy (the policy’s main objective was ‘Health For All’ by
the Year 2000) was approved in 1983 it has the same alphabets as it had in initially.
Null measures have been undertaken “to update or revise the policy even as the
country changes and the new health problems arise from ecological degradation. The
focus has been on epidemiological profile of the medical care and not on
comprehensive healthcare”.

“Socio-Economic Changes”: The rise in educational status of citizens, handsome
salaries, highly paid and shows off posts, increasing awareness about health
advertised by mass media means, soul destroying penetration of media channels all
have contributed to greater attention being paid to health. With degrading joint-family
system and the rise in the system of nuclear families, it regular health check-ups have
become an essential, monthly family ritual. All this has summed up on health
expenses beard by the bread-earner of the family.

Brand Development: Many families run their individual business houses, which
have now also set-up charity hospitals. By lending their name to the hospital, they
develop a good image in the markets which further improves the brand image of
products from their other businesses.

Extension to Related Business: Some pharmaceutical companies like Lockhart and
Max India, have ventured into this sector as it is a direct extension to their line of
business.

Opening of the Insurance Sector: In India, approx. 60% of the total health
expenditure comes from self paid category as against government’s contribution of
25-30 %. Maximum number of private hospitals is beyond the reach of a normal
middle class family. The injection of private companies of insurance sector has given
a new lease of life to the healthcare industry. Health Insurance will be the next hot cake in Indian economy and will make healthcare a household name to a majority of population. Presently, in India a weeny 2 million people (0.2 % of total population of 1 billion), are “covered under Mediclaim, whereas in developed nations like USA about 75 % of the total population are covered under some insurance scheme”. General Insurance Company is severely lagging behind in marketing health insurance. The major drawback in its lagging behind is that “GIC takes up to 6 months to process a claim and reimburses customers after they have paid for treatment out of their own pockets”. This will prove beneficial for private players like Cigna to take the lead in the marathon, which is planning to inject “Smart Cards that can be used in hospitals, patient guidance facilities, and travel insurance” etc.

The “Consultants, Financiers and Insurance Agencies are to benefit from this boom. The insurers will use PPOs, which will grow into HMOs, to assume insurance risks on client’s behalf. Medical Equipments, Medical Software and Hospitals” will bloom and brighten in their full youth.

1.14 Services Provided by Hospitals in Jaipur:-

Hospitals in Jaipur are rapidly getting into pace with international counterparts. They are constantly in the derby of updating themselves with world class environment and facilities for their bread-givers. Few of the common facilities provided by both public and private hospitals are as follows:

- Anesthesia
- Dentistry
- Emergency
- Gastroenterology departments
- Nephrology
- Ophthalmology
- Pediatrics
- Physiotherapy
- Pulmonary medicine
- Cardiac thoracic surgery
- SIDSS(G.I.)
- Dermatology
Hospital Support Services:-

There are enormous health care support services which provide health care services to the hospitals in Jaipur. They are research labs, blood banks, medicine centre etc. These research centers and health care centers or institutes are a state of the art territory care hospital in Jaipur city. These centers are very helpful to the patients and academicians; have knowledge sharing arrangements with various international universities for better assistance of hospitals.

Along with the state of the art medical services, some of the unique features for which these centers stick out like a sore thumb are: nuclear medicine, infectious disease departments, fast track surgeries, and preventive health department and patient education services.

In India we have a standout amongst the most encouraging emotionally supportive network programming id-SA-HIS doctor's facility administration framework programming. It is an item that is a key to encourage doctor's facilities proprietors to
put their arrangement set up and to oversee development, decrease costs, advance procedures, and enhance quiet fulfillment and statutory consistence. It is only extreme among the biggest offering healing center business process change programming for corporate, family, trust, mission and specialist possessed doctor's facilities, nursing homes and chain of centers.

For over 2 decades, this service has been hand in glove with hospital owners and decision makers managing the springs and autumns of growth. It has provoked the element of discipline into administrative aspects by implementing smartly designed, hospital management best practices. Since it has come into action mode it is providing continuous assessment and performance management and audit services.

SA-HIS is like a heaven on earth for hospital owners. It is everything about conveying genuine feelings of serenity to healing facility proprietor cost funds; take inviting, administration control, doctor's facility execution, reporting adaptability and administration unwavering quality. They convey quantifiable cost investment funds for the healing center; give monetary and operational measurements to oversee the clinic; likewise give review administrations to distinguishing holes and enhancing doctor's facility best practices; additionally construct an upper hand through information expository administrations; they go online with existing resources for hospital best practices; low cost ownership; technology handling; hand holding; expertise; flexibility; product range; engagement model are few more examples of existence provided by the SA-HIS to the hospitals all over India as well as now in Jaipur too.

The core of these kinds of support services relies on innovation; they continuously improve the range of informatics solutions provided by them to different hospitals. The innovation they work on is based on research and development which is done by their research and development team and it has come up with breath taking results for the clients of these support services. These innovations are the Cinderella that have helped their clients, partners, care professionals and users to re-incarnate healthcare. These innovations are a concoction of processes and technology outcomes that make their solutions concrete and beyond doubt.
**Government Initiatives:**

India's universal health plan that aims to offer guaranteed benefits to a sixth of the world's population will cost an estimated Rs 1.6 trillion (US$ 24.03 billion) over the next four years.

Some of the major initiatives taken by the Government of India to promote Indian healthcare industry are as follows:

- The Competition Commission of India (CCI) in its colloquium (meeting) has tied the knot on the proposed merger between Sun Pharma and Ranbaxy, subject to the parties inter alia carrying out the divestiture of their products relating to seven relevant markets for formulations.

- India and Sweden celebrated five years of Memorandum of Understanding (MoU). The cooperation in healthcare between India and Sweden will help in filling gaps in research and innovative technology to aid provisioning of quality healthcare.

- Mr. J P Nadda, Union Minister for Health & Family Welfare, Government of India has launched the National Deforming initiative aimed to protect more than 24 crore children in the ages of 1-19 years from intestinal worms, on the eve of the National Deforming Day.

- Under the National Health Assurance Mission, Prime Minister Mr. Narendra Modi's government would provide all citizens with free drugs and diagnostic treatment, as well as insurance cover to treat serious ailments.

- All the government hospitals in Andhra Pradesh would get a facelift with a cost of Rs 45 crore (US$ 6.76 million), besides the establishment of 1,000 generic medical shops across the State in the next few months.

- Mission Indradhanush launched by Mr. JP Nadda aims to immunize children against seven vaccine preventable diseases namely diphtheria, whooping cough, tetanus, polio, tuberculosis, measles and hepatitis B by 2020. Government has set a target of 95 per cent immunization cover by end of 2016.

- The E-health initiative, which is a part of Digital India drive launched by Prime Minister Mr Narendra Modi, aims at providing effective and economical healthcare services to all citizens. The programme aims to make use of technology
Chapter 1: Introduction

and portals to facilitate people maintain health records and book online appointments with various departments of different hospitals using KYC data of Aadhaar number.

**Policy created by Rajasthan government for the development of health care industry:** - Rajasthan, area wise the largest state of Indian sub-continent has population of 56.4 million as per 2001 census. Out of the total state expenses “around 40% of its budget is spent for Social Sectors like Education, Health and Family Welfare, Housing, UDH, and welfare of SC & ST”. A mountainous amount of “Rs. 1100 crore (approximately) was spent on Medical & Health and Family Welfare in 2004-05, about 22% of which was spent on referral health care services. The State Government decided in the year 1996-97 to open up Medical Education to private sector”. On present date, on the heart of the State stands-“8 Medical Colleges of which 2 are in private sector and 6 are in public sector. The intake capacity for Undergraduate course in medicine is 800 (600 in Government and 200 in private colleges) There are 8 Dental Colleges in the State of which one is in Public sector with intake capacity of 40 and 7 are in private sector with intake capacity of 700 seats”. Extravagant hospitals which are run along with the Government Medical Colleges are providing tertiary Health Care services to suffering population of this mother state and adjoining sister states. Also, “Super Specialty Health Care Services like Urology, Pediatric Surgery Neurosurgery, Plastic Surgery, Neurology, Cardiology, Cardiac Thoracic Surgery, Nephrology, Gastroenterology and Endocrinology are available in teaching hospitals of Rajasthan”. State Government is funding independent University of Health Sciences to provide single handed attention to development of Medical Education and research facilities. In order to extol the virtues of recent advances in the field of medicine to residents of inaccessible and remote areas, a telemedicine project is in the line-up in collaboration with ISRO to link Medical Colleges to District Hospitals. The project will maw approximately Rs. 45 crores. There is a need to promote private sector investment in Health Sector in order to facilitate establishing of quality health care institutions within the frame work of set standards and norms. “Private sector can play the mandatory role of a nursing nanny supplementing State Government efforts in the fields of secondary and tertiary health care and diagnostic services”. If state joins hands with private sector it can shower – “overall health benefits it aims to provide in everyone’s kitty, change the
complexion of medical tourism, and expand availability and access of quality health care services”. Also giving a serious thought to budget friendly compositions such as the concoction of allopathic treatment with Indian and other alternative systems of medicine, reducing the aftereffects of solely artificial, chemical-laden allopathic ‘poisons’.

**Objectives of the policy**

The policy created by Rajasthan government has the following objectives:

- To provoke awakening in “private sector investment in Medical & Heath Care Institutions, Medical & Dental Colleges and support units like Diagnostic Centers, Blood Banks and Paramedical Training Institutes”.
- Bringing quality health care under the reach of common man by rational charges.
- To provide nourishing environment for development of “Centers of Excellence for Medical Care”.
- Achieving the primary aim of “promoting Rajasthan as a Medical Tourism Destination” and harvesting foreign currencies out of it.
- To give a kiss of life to Complementary and Alternative Medicine Centers.
- To support and lay the foundation of “Super Specialty Health Care Institutions”.
- To encourage Public Private Participation in Medical & Health Sector to develop standards for infrastructure and operations.
- Setting up and maintaining a regulatory body with supportive role.

**1.15 Hospital Regulatory Framework**

India is upcoming as an untapped market for pharmaceuticals products. Accelerating private health related facilities, inefficient village markets, and constant injection of latest inventions and technologies have given healthcare a reputation of being an independent sector in our country. Increased private companies interference in healthcare is beneficial for medical devices sector which is at its full bloom now. To regulate healthcare and allied services, “the drugs and cosmetic act, 1940 (“D&C, Act) was introduced in India in 1940. However, no separate legislation/regulation has been enacted for regulating the import, manufacture, distribution or sale of medical devices in India till date by the government of India”.

A dim view of Indian history reveals that majority fellowmen then, had nugatory right over latest health-related utilities. Present scenario is opposite. People are now more
concerned and alert regarding health issues in India, quality care service providers offering inviting packages and hefty discounts are ballooning. Thus, Indian healthcare industry has passed its infancy, has become a full fledge tree and will soon be bearing fruits of success.

The Indian economy has the value of about “US $ 1,243 billion and rapidly getting better. The GDP growth reached 9% in the year to march 2008. The 2010-11 budgets extended the coverage to another 20 % of the Indian population covered by the national rural employment guarantee act (NREGA) programmers, who have worked for more than 15 days during the preceding financial year. Budget 2010-11 also allocated US $ 2, 920 million under the national rural health mission (NRHM), an increase of 15% over the previous year”.

Guidelines for medical devices in India- the sad state of affairs is that the “medical devices and surgical instruments are currently not covered under the regulatory framework in India”. But, any device, instrument or structure (however tiny it may be e.g. small sterile needle or insulin syringe) “which is intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder in human beings or animals, as may be specified by the central government by notification in the official gazette would be considered as a drug under the D&C Act and provisions of D&C Act and rules made therein would be applicable on such device”. With day to day and hour to hour health ministry and Indian government of India make amendments in then existing act incorporating new machinery, tools, medical devices and medicines under the D&C Act.

Before 2005, “only medical devices such as disposable hypodermic syringes, tubal rings, condoms, metered dose inhalers, were required to be rejected in India. In 2005, the ministry of health and family welfare (MOHFW) vide gazette notification dated 6th October 2005 further notified 10 sterile devices (“Notified Medical Devices”). to be considered as drug and consequently regulated their import, sale and manufacture under section 3(b) (iv) of the D&C Act”.


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