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PATIENT SATISFACTION WITH PRIMARY HEALTHCARE IN KASHMIR, INDIA - A THEMATIC REVIEW

Saba Amin & Devesh Kumar

Research Scholar, School of Management, Shri Venkateshwara University, Uttar Pradesh, India

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ABSTRACT

The present article is an attempt to analyze the perception of the patients as regards to the services in the primary health centers in Kashmir, India. The paper is aimed to provide an insight into the weaker areas of primary health care that can help the primary health centre administrators to take corrective steps. The paper focuses on the review of patients' satisfaction of primary health centers as suggested in various studies conducted on the theme. The paper is expected to be highly beneficial to primary health service providers to know their problems and prospects in their realm of administration.

KEYWORDS: *Patient Satisfaction, Primary Healthcare, Health Administrators*

INTRODUCTION

Health is considered to be man's most valuable possession for all his activities are influenced by the state of his health. Health has been defined by the World Health Organization (WHO) as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Disease implies absence of ease or comfort. According to Hambers Twentieth Century Dictionary, the meaning of the word disease is 'uneasiness or a disorder or want of health in mind or body or ailment."The profession of medicine has immensely benefited mankind through restoration of good health. According to the New International Webster's Comprehensive Dictionary of the English Language, medical service means assistance or benefit pertaining to medicine or its practice offered to another, i.e., the performance of healing art or the science of preservation of health and of treating disease for the purpose of cure. It should be clear, therefore, that medical services imply delivering quality medical care to the community (i.e. Service of mankind), in treating and curing afflictions of the human body.

The question of professional duty to take care of health has assumed immense significance in the present day world. The Directive Principal of State Policy under the Constitution of India requires the State to make effective provision for public health, and for just and humane conditions of work. It is the primary duty of the State to raise the level of nutrition, the standard of living of its people and the improvement of public health. The Supreme Court has declared that right to medical aid is an integral part of the right to life. It is an obligation on the State to preserve life by extending required medical assistance. In fact the apex Court has held that the right to health and medical care is a fundamental right under the Constitution of India.

The practice of medicine is capable of rendering great service to the society provided due care, sincerity,

efficiency and skill are observed by doctors. The word 'doctor' is derived from the Latin word 'docere' which means to teach. The doctor is a teacher who guides his patients about how to maintain positive health, prevent disease and treat it when the need arises. According to the New International Webster's Comprehensive Dictionary of the English Language, doctor means a qualified practitioner of medicine or surgery in any of its branches and patient means a person undergoing treatment for diseases or injury. Doctors need scientific knowledge, technical skill and above all human understanding. Those who use these with courage, with humility, with wisdom and in accordance with medical ethics provide a unique service to their fellow men and women, and build an enduring edifice of character within them. It is, therefore, anoble profession. Traditionally, the family doctor was considered to be a 'friend, philosopher, and guide' for the sick. The relationship between the patient and the doctor was considered to be very sacred; it was based on mutual trust and faith, and it was not mercenary. Increased mechanization and commercialization of the profession has brought in an element of dehumanization in medical practice. Health care has now been reduced to a business, which determines the patient-doctor relationship.

Patient satisfaction is an important factor for every primary health centers. Therefore, the primary health centers have to try to provide better facilities to the society. The primary health centre swills have to gear up to meet the present needs of the people. Nowadays the lifestyle of the people in the society has changed than before. As a result, very serious diseases occur in the society. The poor and downtrodden masses who cannot afford the luxury of the private primary health centers throng the portals of the primary health centre for tor free medical care. Therefore, expenditure on public health care by the government has escalated sky high. The Government has to allocate sufficient funds in every budget to augment and provide the latest facilities to the masses that depend on the primary health centers.

Today, the common opinion on the primary health centers is not encouraging. There are perennial complaints that sufficient drugs are not available in the primary health centre sand funds are not sufficient.

In this context, study is highly essential to evaluate the satisfaction levels of patients towards services rendered by the primary health centre so that these primary health centers can affect proper midway corrections in their functioning to provide better facilities and generate a perception of satisfaction all around.

THE HEALTH CARE SECTOR IN INDIA

India's health care system is characterized by a pattern of mixed ownership and with different systems of medicine – Allopathy, Ayurveda, Unani, Siddha and Homeopathy. Three major groups in health care in the country, the public health sector, the private health sector and the households who utilize health services. The public health sector consists of the central government, state government, municipal and local level bodies. Health is a state responsibility; however, the central government does contribute in a substantial manner through grants and centrally sponsored health programs/schemes. There are other ministries and departments of the government, such as defense, railways, police, ports and mines who have their own health services institutions for their personnel. For other organized sector employees (public and private) provision for health services is through the Employee's State Insurance Scheme (ESIS).

The private health sector consists of the 'not-for-profit' and the 'for-profit' health sectors. The not-for-profit health sector includes various health services provided by Non-Government Organizations (NGO's), charitable

institutions, missions, trusts, etc. healthcare in the for-profit health sector consists of various types of practitioners and institutions. The licensed practitioners range from general practitioners (GPs) to the super specialists, various types of consultants, nurses and paramedics, licentiates, and rural medical practitioners (RMPs). The health care practitioners with no formal qualifications constitute the 'informal' sector, which consists of faith healers, local medicine men/women, traditional birth attendant priests and a variety of unqualified persons. The private health subsector institutions are heterogeneous in the services they provide, their size and quality.

The Public Health Sector in India

The public health system in India is financed by the Central, State and Local governments, though the first two are the most important. Health is a state subject and the state governments are responsible for the delivery and financing of public health services. However, the central government plays an active part in the promotion and financing of certain health programs through centrally sponsored schemes. These are typically disease specific prevention programs like malaria prevention. Public spending on health is low in India and has remained stagnant at around 1% of the gross domestic product. However, there are considerable interstate variations in health spending with some states like Kerala, Punjab and Tamil Nadu spending twice per capita compared to states like Bihar and Madhya Pradesh (Peters et al. 2002). On the other hand, private spending on health care is extremely high and accounts for nearly80% of all health spending. Most of this is out-of-pocket payments made to private providers at the point of use. This reflects the dominant role the private sector now plays in the provision of curative health services. India's health system has been particularly unfair to the poor. Benefit incidence studies have shown that public subsidy for curative care is heavily skewed towards the rich with the richest 20% of the population receiving more than three times the subsidy the poorest 20% receives (Mahal, Yazbeck, Peters, and Ramana, 2001).

Thesis due to publicly provided services being skewed towards the rich, and that the richer groups tend to use the costlier hospital based services more than the poor. However, public subsidy on outpatient care at the primary health care level tends to be pro-poor in its distribution. Similarly for public subsidy on immunizations and antenatal visitant primary care facilities. Despite these inequalities, the public health system plays an important role in providing health care to the poor. For example, 61% of hospitalizations for those in the poorest income quintile occurred at public hospitals compared to 31% for the richest quintile. Similarly, 73% of institutional deliveries per1000 births in the poorest income quintile were at public facilities compared to 36%for those in the richest quintile.

There is utter neglect of rural areas in provision of medical care services. The government conveniently took up the responsibility of preventive health services and left the curative care largely in the hands of the private health sector. It has been clearly shown time and again by various studies the rural-urban disparities in terms of health infrastructure is very wide. Analysis of total state expenditures on health reveals that between 70% to 80% of the investment and expenditure reaches 30% of the population in urban areas. For instance, in 1991 of all hospitals and beds in the country only 32%, and 20% respectively were in the rural areas i.e., 20 beds per1,00,000 population in rural areas as compared to 238 beds per 1,00,000 population in urbane areas. The poor in the villages were given inferior health services in the name of Primary Health Care, National Programs. For the rural population there is very little provision of state funded curative care though these services are most demanded. Studies conducted reveal the fact that Primary Health Center's are grossly underutilized primarily because they have inadequate resources (staff, medicine,

equipment, transport) and because the entire focus of the health program is in completing family planning targets. The loss of faith in the public health sector has provided the private health sector, an opportunity to thrive and make its presence felt as the sole provider of curative care in the rural areas.

The Private Health Sector in India

The private health sector in India is the most dominant sector in terms of financing and utilization of health services. There has been a tremendous amount of growth in physical size, investments, expenditures and utilization. The significance of the private health care sector in India can be summarized as follows (Bhat, 1999):

- Total health expenditure in India is estimated to be about 6% of GDP, of which private health care expenditure is 75% or 4.25% of GDP. About one-third of this expenditure is on secondary and tertiary inpatient care, the rest meeting the creative needs at primary level. Insurance coverage mechanisms are
- Negligible and most of this expenditure is out-of-pocket.
- Private health care expenditure in India has grown at the rate of 12.5% per annum since 1960-61. For each 1% increase in per capita income, private health care expenditure has increased by 1.47%.
- About 57% of hospitals and 32% of hospital beds are in the private sector. The share of private sector investment in total health infrastructure, e.g. hospitals, investment in medical equipment and technology, is also quite significant.
- At present about 80% of 3, 90,000 qualified allopathic doctors registered with medical councils in India are working in the private sector. There are over 6,50,000 providers of other systems of medicine practicing in India and most of them are in private practice.

Utilization studies show that one-third of in-patients and three-quarters of outpatients utilize private health care facilities. Health planners and policy makers among others have failed to take a holistic assessment of the private health services in the country. There are very few studies conducted on the role, functioning, size and quality. Data presented by official agencies has been found to be grossly underestimated (Nandraj, 1994). Recent studies on utilization patterns of health care facilities indicate that the role of private health care has significant implications for cost and quality of health care services. There are cases of superfluous and high costs for services rendered by private physicians and hospitals, but there is no evidence that these result in any greater use of public facilities. Significantly, there has been little effort to draw up regulatory mechanisms to promote the development of the private health care sector in an appropriate direction, even when there is evidence of extravagance and abuse (Bhat, 1993).

Private health facilities tend to perform unnecessary investigations, tests, consultations and surgeries, as well as overcharge and over-prescribe. Due to the fact that surgeries are profitable, many are conducted without any regard for the patients well being. A study revealed that 31% of deliveries were by cesarean section. More significantly 70% of the hospitals where cesareans were routine were privately owned. Ultrasound investigations, amniocentesis, epidural anesthesia, etc. are also done unnecessarily more frequently in order to recover investment costs. The rising costs of health care are also due to the irrational and unethical practices resorted to by the private health sector. For specialized treatment like hospitalization and investigations, for each referral made, a part of the fee charged to the patient is given

to the referring doctor. In Mumbai, the profit-ratio is as high as 30% to 40% of the fees charged (Nandraj, 1994).

In many private hospitals, there is pressure on the doctors to ensure that the beds are occupied and the hospital equipment is fully utilized. Many hospitals fix the amount of 'business' a physician or surgeon must generate. Many of the private hospitals refuse admission to patients unless a certain deposit is paid before hand, regardless of the severity of the patient's health status. This is inspite of the fact that the patient may be seriously ill or an accident victim.

In India the private health sector functions practically unregulated and unaccountable to the people or any authority. There are no standards of medical practice prescribed for private hospitals in terms of qualification of staff employed, equipment needed, administration, treatment offered. Only recently the private practitioners were brought under the preview of the Consumer Protection Act, a policy which was met with great resistance from the medical fraternity.

Except for the states of Delhi, Maharashtra and Karnataka there are no rules, laws, or regulations for private hospitals functioning. The practitioners are supposed to function broadly under various medical councils set-up for various systems by law. However, the functioning of the medical councils in the country leaves much to be desired. Majority of the people utilize the services of the private health sector but have, little or no control on the quality or pricing. The various studies conducted have revealed that households spend a substantial amount on health care and the poorer class spends more on health care in terms of their proportion to consumption expenditure and income. Findings from various studies make it evident that a substantial financial burden of the household is borne for meeting health care needs.

Compared to government expenditure on health the private household expenditure is nearly 4 to 5 times more. A substantial portion of their income and consumption expenditure is spent on health. This certainly is not a happy state of affairs, since such expenditure on health care would mean cutting down on the household food consumption. This gains significance when we realize that nearly half of the country's population does not have enough resources to meet their food requirements, and worse still the capacity to earn if the patient happens to be the sole earning member. Given this socio-economic situation in the country, the purchasing power becomes a critical factor, as we have seen above the accessibility of the public health service is poor especially in rural areas of the country. The private health sector becomes unaffordable for the vast majority of the poor. There is the impoverishment of the lower class or middle class due to illness which could be of a chronic nature or that involving hospitalization or surgery. The high cost of healthcare makes the poor more marginalized. There is a need to question the dominant role of the private health sector and consequently, high health care expenditure.

PATIENT SATISFACTION

Patients are people with defined medical conditions seeking treatment. Since the 1980s, interest in the measurement of patients' satisfaction with their health care experiences has increased, following reports that high patient satisfaction is associated with better health outcomes."Patient satisfaction can be defined as a judgment made by a recipient of care as to whether their expectations for care have been met or not". (Palmer et al. 1991).

The patient`s judgement or assessment is very subjective, a very personal one. It is based on the perception of care and is responsive to the patient's personal needs, rather than to any universal code of standards. Thus, the

healthcare organization has to measure, analyze and report the degree to which they are meeting the patient needs.

Thus, studying patient satisfaction with medical services is very important. Patient satisfaction survey provides very important and useful important information about the quality of health services, and this information is valuable to health care providers in evaluating health and medical care services. Then they can improve their services according to patient's needs and perceptions. Patient's information about the feedback also contains the information about the structure process and outcome of health care (Marquis, et al. 1983). Finally, patient satisfaction is related to health and illness behavior. It is widely accepted that satisfied patients will adhere to the physician's recommendations for treatment use their medications and keep their future appointments.

Duckkett (1983), had stressed the need for the JCI accreditation in hospital industry for improving its quality of service and also profitability. The hospital should render the service on par with an international standard to survive in the competitive industry. It is possible only when there is an establishment, of the JCI accreditation.

Donabedian (1988), had pointed out that since patients are often unable to accurately assess the technical quality of health care services, functional quality had become usually the primary determinant of patients' quality perceptions.

lrudayaRajan (1995), in his study, had pointed out that utilization, as well as the development of the private sector, has become a vital factor in Kerala, especially in the 1980's,the utilization of private institutions by the poorer sections of the population indicates the health consciousness among Keralites and the poor performance of public health care institutions.

Bolton and Drewy (1995), said that there is growing evidence to suggest that perceived quality is the single most important variable influencing customers' value perceptions. These value perceptions, in turn, affect customers' intentions to purchase products or services.

PrasantaMahapatra et al., (2007), in their patient contentment survey, found out that the level of patient satisfaction was about 65 percent. The main reason for their displeasure was corruption in the primary health centers, which was rampant. Other significant areas of hospital services contributing to patient displeasure were lack of basic utilities like water, fans, lights, poor maintenance of toilets, lack of cleanliness, and poor interpersonal relationship.

Bart et al., (2014), had found grant-in-aid primary health centers to be relatively more efficient than the public primary health centers. In their study, the management and administration of the primary health centre were found to have a significant impact on the performance of a hospital.

Noor Azlinna Azizan and Bahari Mohamed (2013) had focused on the effects of perceived service quality on patient satisfaction in a public hospital. They had concluded that the infrastructure and interaction constructs were not considered very important in determining the perceived service quality from the patients' perspectives. Therefore, hospital leaders should place more emphasis on these constructs.

Manimaran S. et al., (2014) had analyzed the overall service quality gap between patients' expectations, perceptions and improvements will be required across all the following five dimensions namely,Tangibility,Reliability,Responsiveness,Assurance, and Empathy.

Mohsin Muhammad Butt, Ernest Cyril de Run (2010), found that a moderate negative quality gap for overall Malaysian private healthcare service quality was indicated. He had also pointed out that a moderate negative quality gap on each service quality scale dimension had existed in the primary health centers. He had offered a way to assess private healthcare service quality. Secondly, he had successfully developed a scale that can be used to measure health care quality.

Parvez A. Mir (2015), had viewed that health care sector is developing at a very fast pace. People are becoming more and more health conscious and are demanding better quality health care measures. In hospital industry, if a patient is a raw material and the patient satisfaction is the end product, the fierce competition, lead us to realize that all primary health centres need to improve their services quality. To develop and maintain the hospital image, it was suggested that the hospital organization should develop patient-focused care for its long-term survival and it can achieve only by focusing on continuous quality improvement and coordination among the various departments in delivering the value care to achieve the desired outcomes.

Karthikeyan and Thirunarayanasamy (2015), found that a moderate negative quality gap for overall Malaysian private healthcare service quality was indicated. He had also pointed out that a moderate negative quality gap on each service quality scale dimension had existed in the primary health centre shad stated that patient satisfaction is becoming an increasingly important issue, in terms of both evolution and the shaping of healthcare. Patient satisfaction can help to educate medical staff about their achievements as well as their failure assisting them to be more responsive to their patient's needs. Their finding of the study was that the majority of respondents had felt that more or less the behavior of all doctors is good. The attitude of nursing staff behavior was also good. The room services were found satisfactory in selected primary health centres. They were of the opinion that patient satisfaction survey should be carried out routinely in all aspects of healthcare to improve the quality of services. Further, they were of the view that providers of hospital facilities should take some measures to improve some weaker areas like an expression of language and medical terms used by doctors, attitude and behaviour of nursing staff and the quality of food provided in rooms.

Patawayati et al., (2015), had concluded that the trust variables play an important role in improving patient loyalty, for it is the management of the public hospital that needs to maintain and enhance trust through better system services. In addition, it was viewed that the commitment to variable roles to increase the loyalty of the patients, the management of the hospital needs to maintain and enhance this commitment into a relationship at any time especially for patients in treatment. Finally, it was stated that beliefs affect patient loyalty. Commitment to improving patient loyalty may increase the patient's trust and commitment.

Jeyalakshmi. A (2016), had surmised that the development of health care facilities is influenced not only by the opening of primary health centers, but more so by their administration and management. She had pointed out that hospital management has become a place of despair to the patient. Hospital management is different from industrial management because the hierarchical form of management followed in industrial organization is not suitable for primary health centres.

CONCLUSIONS

This paper is expected to be beneficial to the government health policy makers and future research scholars

who venture to do further research in this field. This review may also prove useful to the academic fraternity in the medical and humanities universities besides being highly useful to the public who are the ultimate beneficiaries of these facilities.

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