

**CEHAT Research Programme for Improving Quality of Health Care in Public  
Hospitals**

**Patient Satisfaction in the context of  
Socio-Economic Background & Basic Hospital Facilities  
A Pilot Study of Indoor Patients of L.T.M.G. Hospital, Mumbai**

**Aditi Iyer  
Amar Jesani  
Santosh Karmarkar**

**CEHAT  
(Centre for Enquiry Into Health and Allied Themes)**

**in collaboration with  
L.T.M.G. Hospital, Mumbai & Sion Senior Citizen's Association, Mumbai**

# Table of Contents

I	ACKNOWLEDGEMENTS
II	REPORT
<b>Section 1</b>	<b>Introduction</b>
<b>Section 2</b>	<b>Methodology</b>
<b>Section 3</b>	<b>Findings</b>
	<b>1. Profile of patients and their households</b>
1.1	Department-wise breakup of patients
1.2	Duration of stay in hospital
1.3	Age
1.4	Occupational and Income Profile
1.5	Educational Profile
1.6	Religion and Caste
1.7	Residence
1.8	Living conditions
	<b>2. Treatment before LTMGH</b>
2.1	Duration of illness and medical help sought
2.2	Providers approached and changed
2.3	Expenditure incurred
2.4	Familiarity with LTMGH
2.5	Reasons for coming to LTMGH
	<b>3. Experience of indoor care at LTMGH</b>
3.1	Gaining access
3.2	Quality and adequacy of physical facilities
3.3	Inter-personal relations
3.4	Medical facilities
3.5	Expenditure at LTMGH
	<b>4. Satisfaction</b>
4.1	Satisfaction with physical facilities
4.2	Satisfaction with health workers
4.3	Reasons for satisfaction
4.4	Patients' charter of recommendations
<b>Section 4</b>	<b>Conclusions and Recommendations</b>
<b>Section 5</b>	<b>Tables</b>
III	ANNEXURES
Annexure 1	Interview Schedule for in-patients
Annexure 2	Information on Hospital Wards

## **Acknowledgements**

The study owes its existence to a number of people to whom we offer many thanks.

- To the Dean of Lokmanya Tilak Municipal General Hospital, Dr. R.G. Shirahatti, whose commitment to quality sparked off a collaborative venture with CEHAT and Sion Senior Citizens' Association.
- To the Sion Senior Citizens' Association and its President, Mr. M.A. Telang and other office bearers who willingly participated in the collaborative venture.
- To our interviewees - the in-patients - who bore the brunt of our questions with grace and fortitude.
- To our interviewers - Mr. C.V. Dalvi, Mr. R.M. Joshi, Mr. K.G. Kirane, Mrs. S.S. Korke, Mr. N.D. Parekh, Mr. M.R. Patil, Mr. J.V. Shah, Mrs. S.P. Shastri, Mr. R.P. Sheth, Mrs. K.B. Vora from Sion Senior Citizens' Association - who rose to the challenge of an unfamiliar and physically taxing activity and persisted till the end.
- To the Sisters-in-charge of the wards who took the time to fill our questionnaire.
- To Ms. Anjana Das, Public Affairs Centre, Bangalore who generously shared her experience of a similar study in Bangalore.

And finally, to the researchers at CEHAT, specially Ms.Neha Madhiwalla, Mr.Sunil Nandraj and Ms.Roopashri Sinha, who infused energy and enthusiasm into the study and supported it in a million ways.

## **Introduction**

This report presents the findings of a pilot survey of patients' satisfaction in Lokmanya Tilak Municipal General Hospital (LTMGH) in Mumbai. The study situates satisfaction in the context of the socio-economic background of patients as well as the physical and medical facilities provided by the hospital.

Attitudinal studies of patients as mechanisms for articulation and response have begun to play an increasingly useful role in health care management. This arises out of a growing need for quality assurance of health care systems. At the heart of this drive lies a concern for the recipients or users of services. The study of patient's satisfaction is thus an integral element of quality assessment. However, it cannot be treated as an end in itself. For while satisfaction is reflective of quality, it is equally an outcome of the patients' social orientation and expectations. Therefore, satisfaction is a subjective state, a mediation of objective reality.

In contrast, quality of health care encapsulates not merely a satisfied clientele but also a service that complies with approved physical, medical and professional standards. These indicators lie outside the patients' consciousness. The attainment and maintenance of standards are made possible by continuous monitoring and feedback. In this context, the present study can be seen as the first of many endeavours that may be repeated in future.

## Methodology

### 1. Study of In-patients

The study adopts a fairly basic methodology: a brief round up at one point using the survey method. The choice of a quantitative methodology was determined by the notion of feasibility. Firstly, since the time available for designing, conducting and analysing the findings of the study was all of 30 days, the research team did not have the liberty to experiment with an innovative methodology. Secondly, since the interviewers were going to be volunteers from the Sion Senior Citizens' Association with no previous experience in research, it was necessary to demystify the interview, the interview schedule and the mode of recording information. Keeping all these considerations in mind, we relied on the tried-and-tested survey with a focused close ended interview schedule.

Our interviewers were motivated, articulate and committed to the novelty of the research enterprise. However, due to the paucity of time, “training” was necessarily superficial. The “training” sessions consisted of merely discussing and modifying the interview schedule. The more intensive discussions through which biases in the research process become transparent were not possible.

The units of analysis were patients. Again due to considerations of feasibility (namely, time, finances and personnel), the study could cover only the experience of *in*-patients who, by virtue of their immobility, were relatively more accessible to the interviewers. By that token, they were interviewed at a time when they were greatly dependent on the hospital and its staff. It is likely that this vulnerability would have affected their responses.

The study was conducted in the first half of June 1996. This is a relatively lean period in Mumbai as summer vacationers only just begin to return to the city. Therefore, while the hospital's bed strength enables it to accommodate 1278 in-patients (excluding 126 beds in the Dharavi Urban Health Centre), the number of admissions was much lower. The size of the sample attained at the end of two weeks was 123. This is approximately 10% of the bed strength. When compared with the number of admissions, this proportion is really larger. However, we do not have statistics to prove this contention. Table 1 chalks out the bed strength of each of the wards covered by the study and Table 2 provides details about the distribution of the 123 in-patients in the different wards.

Patients were chosen by the simple random method. In their original brief, interviewers were told to approach patients in every seventh bed. However, this pattern could not be uniformly achieved since there were vacant beds (given the relatively low bed occupancy at the time) and temporary vacancies (occasioned by patients being taken to the OPD or operation theatre or for diagnostic tests). In such cases, the next bed was usually identified.

The tool of data collection was an essentially close ended interview schedule (see Annexure 1). Responses to the close ended questions were categorised in advance while responses to the few open ended questions were first listed and categorised before being

coded. Analysis of data gathered by the interview schedule was done using SPSS for windows, a statistical package for the social sciences.

The findings of this survey have been coloured by the fact that interviews were conducted in the hospital while patients were still in the process of treatment. Such an approach has the advantage of capturing an experience in process but the influence of the hospital environment and the physical and emotional vulnerability incumbent on the patients' psyche has affected the responses. Perhaps this can be rectified at a later stage by an exit survey where it will be possible to capture concluded experiences without too long a recall period. Such a study could be conducted on a continuing basis. Here the involvement of groups like the Sion Senior Citizens' Association, which is an external agency, would be beneficial. Such groups could be involved in monitoring the activities of the hospital in the long term.

## **2. Compilation of Medical Information about patients**

Since the interviews were conducted by non-medical persons, we enlisted the help of interns for medical details about each of the patients in the sample. Their brief was to get information about medical diagnosis; medicines and tests prescribed and provided by the hospital.

By the time this exercise got underway, the case papers of most of the patients in the Obstetric/gynaecological wards had been sent off to the Medical Records Office. Unfortunately, there was no time to access it. This meant a significantly large number of "No Responses" that was inadmissible from the researcher's point of view. Therefore, the effort that went into this process was in vain.

## **3. Study of physical facilities in the wards**

To place the experience of physical facilities in context, we circulated a questionnaire to all the wards (Annexure 2). The questionnaire asked for information on bed allocation and admissions as well as supply, use and availability of physical facilities and personnel on one working day. This questionnaire was filled up by the Sisters-in-charge.

The outcome of this exercise was a database of varying quality. Some of the questionnaires were incompletely filled up and some did not conform to the prescribed format. Information on bed allocation and occupancy per unit as well as male-female differentials was particularly indifferent. At any rate, we have brought only data on the non-emergency wards into the present analysis.

# Findings

## 1. PROFILE OF PATIENTS AND THEIR HOUSEHOLDS

### 1.1 Department-wise break-up of patients

As shown in Table 2, the four departments that accounted for 68.3% of all patients in the sample were Obstetrics & Gynaecology (22%), Medicine (21.1%), Surgery (16.3%) and Orthopaedics (8.9%). These four departments have a substantially large allocation of beds in the hospital too when you include all non-paying and paying beds in the regular and emergency wards (and exclude the Dharavi Urban Health Centre). As Table 1 shows, this number works out to 807 out of a total of 1278 beds (or 63.1%). Further, 6.5% of the patients from our sample were in the Ophthalmic Department even though this department has only 3.4% of all the hospital beds. This is because patients were far more than beds at the time of our interviews.

When this distribution incorporates a gender dimension, a distinctive trend emerges. As many as 57.4% of all female patients were clustered in the Obstetric & Gynaecological wards (57.4%) while male patients were spread somewhat more equitably in the medical, surgical and orthopaedic departments (22.4%, 23.7% and 9.2% respectively).

This gender bias shows up more plainly when one analyses the allocation of beds per ward. Table 1, which presents information provided by the hospital's administration, substantiates this contention with statistical evidence. At an aggregate level, the gender differential in bed allocation is marked: the 32.9% allocated for female adult patients are substantially lower than the 46% earmarked for male adult patients. However, a closer look at the disaggregated figures shows that this proportion is not just insubstantial but also somewhat distorted.

The distortion occurs due to the inclusion of 200 all-female beds in the Obstetric and Gynaecological beds (or 15.6% of all hospital beds) in the total. When these are excluded from the analysis the yawning gap between 54.5% "male" beds and 20.4% "female" beds gain sudden visibility. We will return to this finding while making recommendations.

### 1.2 Duration of stay in hospital

The average duration for which patients were admitted in hospital was six days when calculated as a median and approximately 10 days when calculated as a mean - Table 3. The range was a wide one from zero to 66 days with 58.5% spending seven or fewer days as in-patients. So the mean has obviously been affected by extreme values.

When this data is viewed across departments, we find marked differences in the average (that is, median) duration of admission. The larger departments (namely, medicine, surgery, obstetrics and gynaecology) tended to have a relatively quick turnover since patients were not kept for more than six days on an average. Patients in the orthopaedic

department, on the other hand, were kept for nine days while those in the departments of urology, CVTS and ophthalmology were kept for 25 days, 15 days and 13.5 days respectively. These are interesting findings. However, the absence of medical information makes it impossible for us to judge their rationality.

### **1.3 Age**

The average age of patients was 30 years when calculated as a median and 34.6 years when calculated as an arithmetic mean - Table 4. The age distribution showed somewhat poor representation of the two extremes of the life cycle: children below five years constituted a mere 5.7% and patients over the age of 55 years comprised 14.7% of the sample.

In contrast, exactly half the patients were clustered around the 18 to 45 age group. This proportion goes up to 65.9% among all female patients. This age group is conventionally looked upon as the 'reproductive age group'. In this context, it is interesting that more than four fifths of these women (or 83.9%) were admitted for obstetric and gynaecological care. Therefore, medical intervention coinciding with the socially sanctioned role of child bearing appears to be clearly indicated for female patients.

In comparison, 48% of the male patients tended to be grouped around the 26-55 age interval, 94.4% of whom were receiving independent wages or earning independent incomes. Therefore, slightly less than half the male patients were economically productive agents before their hospitalisation. What this amounts to will be taken up in the next section.

### **1.4 Occupational and Income Profile**

At least four out of five in-patients lived for most of the year in urban areas (including the 70.7% who lived in Mumbai and the 11.4% who lived in urban Maharashtra) - Table 13. So non-agricultural occupations featured in the occupational profiles of nearly two fifths of the sample. This includes 14.9% who worked in the organised industrial or white collar sectors, 10.5% who were self employed as skilled workers or petty traders, and finally 13.2% who were manual labourers.

These details are interesting enough. However, they somewhat pale when compared with the overwhelmingly large number of non-earners: as many as 62 out of 114 patients in the sample (or 54.4%) were non-earners. Included in this group are housewives, students, unemployed and retired persons. While acknowledging that four of the retired persons were pensioners and sole economic actors in the household, we justify their inclusion in the category because they were exceptions rather than the rule.

The average monthly incomes earned by patients rose appreciably from the agricultural to the non-agricultural sector (Rs.843 to Rs.2357) - Table 7. Within the non-agricultural sector itself there were vast differences between the unorganised and organised sectors: manual labourers earned an average income of Rs.1667, artisans and petty traders earned



Rs.2008 and industrial and white collar workers earned Rs.3212. In some ways, this is an expected finding.

However, due to the substantial presence of non-earners in the sample, the average (i.e. mean) income is a low figure of Rs.967.12. When the average is calculated as a median, this figure plunges to zero. When incomes are calculated as percentages of total household income, an average (mean) figure of 37.7% presents itself - Table 8. On the whole, therefore, patients played a somewhat marginal role as economic agents in their households. This economic role would, probably, affect their status in the household and consequently their access to medical services but the absence of community data prevents us from engaging in a full fledged discussion on the subject.

The average monthly household income was Rs.2000 (median income) and Rs.2749.50 (mean income) - Table 10. The latter has been somewhat distorted by the 9.6% households that registered monthly incomes in excess of Rs.5000. However when these are converted to per capita monthly incomes, average figures of Rs.428.6 (median) and Rs.625.6 (mean) present themselves. These figures are slightly higher than the Planning Commission's urban expenditure poverty line of Rs.300 per capita per month at 1992-93 prices. As many as one fifth of all households made do with per capita monthly incomes below Rs.250. This is a startling finding.

There were clearly defined relationships of economic dependence. A rough ratio of two non-earners to one earner is evident. The profile of economic activity and dependence begins to get clearer when it incorporates a gender dimension. We now find that as many as 41 out of the 62 non earners (that is 66.1%) were female - Table 6. When this number is measured as a proportion of all female patients, a ratio of roughly nine out of ten (or 89.1%) presents itself. This is significantly higher than the proportion of male non-earners (which is 35.5%) - Table 6.

Further, unlike female patients, male patients showed significantly larger representations in the service sector (23.9% as against 2.1%) and small trade (16.4% as against 2.1%) and, indeed, even in manual labour (17.9% as against 6.5%) - Table 8. Therefore, the sexual division of labour obtaining in the labour market was very noticeable and patients were quintessential products of it.

Stemming from the starkly contrasting occupational profiles of male and female patients are substantial differences in earned incomes: Rs.1433 (which is the income of male patients) versus Rs.198 (which is the income of female patients) - Table 8. Unlike female patients who were essentially economic dependents, more than half of all male patients were main earners in their households. On the whole, the average (i.e. mean) contributions were 57.9% (for male patients) and 5.7% (for female patients) - Table 8.

Thus gender specific scenarios of economic activity were in existence. This finding could influence specific recommendations but the fact that patients largely come from the poorer classes remains beyond dispute.

## **1.5 Educational Profile**

Although the educational profile of patients shows a fairly high level of “literacy”, patients evidently did not have the benefit of long exposure to the education system. The proportion of literate male patients was 85.2% which is slightly lower than the 1991 census figure of 87.9% for Greater Bombay. On the other hand, the proportion of literate female patients (72.1%) was noticeably lower than the census figure of 75.8%.

On the whole, one fifth (or 20.2%) of all patients excluding students was completely illiterate - Table 5. While nearly one fifth (or 18.3%) received primary level schooling, a majority of the patients were high school drop-outs (33.7%). The proportion of patients with post-matriculate education was low (barely 10.5%) and lower still among female patients.

## **1.6 Religion and Caste**

A majority of the patients were Hindus (74.8%) followed by Muslims (10.6%) and Buddhists (6.5%) - Table 11. It has not been possible to get caste related information about religions other than hindus. The data shows that a majority of the hindus belonged to the upper castes (including Brahmins, Rajputs, Marathas) followed by the middle castes (under which umbrella we have included the occupational castes) and lastly scheduled castes (13%). The proportion of scheduled castes in our sample is exactly twice the 1991 census figures for Greater Bombay.

## **1.7 Residence**

The largest numbers of patients were those who lived for most of the year in Mumbai (87 or 70.7%). When you add to this, the numbers who came from urban and rural Maharashtra, the proportion went up to 92.6%. Therefore, the hospital has largely remained a metropolitan institution. Its role as a regional centre is indicated but to no great significant degree.

## **1.8 Living conditions**

A majority of patients (71.4%) lived in slums, chawls or on the pavement, mainly in the city - Table 14. Patients dwelling in flats or independent dwellings were in a minority (15.1% and 13.5% respectively). The latter specially were not residents of Mumbai.

These dwellings did not offer the luxury of space. The average area per capita was 57.1 square feet when calculated as a mean and 40.6 square feet when calculated as a median. There were significant differences in the average figures across the three groups. However, for most patients this space was no more than 47.8 square feet (mean) or 30 square feet (median). These were cramped living quarters by any standard but not surprising in a city like Mumbai. Most of these dwellings were rented.

There appears to be some congruence between housing and economic status. Half the patients living in slums, chawls and on pavements earned less than Rs.2000 while more than half of those living in flats earned more than Rs.2000. The only discordant note was

struck by one flat dweller who reported a monthly income below Rs.1000. This definitely appears to be an under-reported figure.

On the whole, when data about living conditions is fed into all the other social and economic data in the paragraphs, it becomes obvious that patients seeking indoor care at LTMGH are in many ways disenfranchised members of society.

## **2. TREATMENT BEFORE LTMGH**

Do in-patients come directly to LTMGH or do they come through a chain of referrals by other providers in the public and private sector? Why do patients come to LTMGH for indoor care? To be informed about this we asked patients about their current episode of illness: When did their complaints start? Which providers did they approach and for how long? Why did they change providers? Finally, how much did they spend on treatment before admission in hospital?

### **2.1 Duration of Illness and Medical Help Sought**

The most significant finding in Table 15 relates to the time for which patients have been suffering from their present illness. Nearly three out of five (that is 75 out of 122 or 61%) were ill for more than three weeks. This indicates that in-patients were seeking treatment for chronic complaints. Sadly, the study does not succeed in capturing information on the acute phase that prompted help seeking. This is a limitation of the information on duration.

The patients whose complaints lasted for less than three weeks constituted 21.8% of the sample (including 8.9% who were ill for one week or less, 3.2% who were ill for eight to 14 days and 9.7% who were ill for 15 to 21 days). The 16 patients listed under the 'Not Applicable' category were pregnant and not exactly unwell.

### **2.2 Providers approached and changed**

The tendency to seek medical help appears to bear some direct relationship with the length of their present illness. This is not an extraordinary trend. As Table 15 shows, the proportion of those approaching no provider decreased steadily with time: from an initial ratio of 72.7% among patients ill for one week or less, it came down to 50% before dipping further to 25% and 21.6%. It is this ratio of 21.6% that is precisely the more significant finding. That one in five patients suffering from chronic complaints do not have the benefit of medical care before a tertiary level medical facility is a cause for some concern.

Roughly one third of all patients (that is, 39 or 32%) did not seek medical treatment from other providers before coming to LTMGH. Included in this group are police or accident cases who were brought directly. Despite being a tertiary facility, the hospital in fact serves as a primary facility to quite a significant degree. The data shows that this is so not only for the group of *regulars* (who constituted 46.2%) but for *first timers* too (who constitute 53.8% of the patients in this group).

Table 16 provides information on the number and types of providers approached before LTMGH. Apart from the 39 patients who have been discussed in the previous paragraph, 62 patients (or 50.8%) went to one provider, 12 (or 9.8%) went to two providers and nine (or 7.4%) went to three or more providers.

Most of these providers were located in the private sector - Table 16. Exactly half the patients approached private practitioners at the first instance while less than one fifth (or 16.4%) went to other government or Municipal-run institutions. On the whole, 115 providers were approached before LTMGH. Nearly three out of four of these (or 73.9%) were medical providers in the private sector (including the private NGO sector). Medical providers in Municipal or government run health institutions were restricted to one fourth (or 24.4%). The tendency to seek medical care and to change providers begins one fortnight after the complaints first appear. This trend is apparent in Table 15.

Two main reasons prompted patients to discontinue treatment and switch providers (including LTMGH). These are presented in Tables 17 and 18. The first, which amounts to 47.4% of all reasons stems from the persistence of symptoms (Table 17). To that extent, treatment was perceived to be ineffective. This often led to a general disillusionment with the provider. This dissatisfaction was more acutely felt among patients taking treatment from private practitioners. About 55.7% of the practitioners in the private sector were changed due to this reason as against 24% of practitioners in the public sector.

When a time dimension is added to this, it becomes apparent that dissatisfaction with the private sector creeps in earlier than it does in the public sector - Table 18. Eleven patients (or 28.2%) felt this within one week of treatment while eight (or 20.5%) felt this within eight to 14 days of treatment and 20 (or 51.3%) felt disillusioned more than 15 days after treatment. In contrast, disillusionment came more than 15 days after treatment in public health facilities.

Referrals to LTMGH or to other specialist facilities elsewhere constituted the second major reason for discontinuance of providers (to the extent of 33%) - Table 17. This was indicated to a somewhat greater extent among practitioners in the private sector although the difference between the two sectors is not great: 28% in the public sector versus 34.3% in the private sector respectively. Referrals are more quickly made in the private sector too. As Table 18 shows, 58.3% were made within one week of treatment. When you consider a fortnight an indicative period, this proportion goes up to 70.8% in the private sector as against 42.9% in the public sector. Most of the referrals in the public sector (that is, 57.1%) take place after more than two weeks of treatment.

The third reason - namely the absence of required facilities - was cited by nine patients (or 9.3%). This was more acutely felt in the public sector (28% as shown in Table 17) and more quickly perceived (71.4% within one week of treatment - Table 18).

### **2.3 Expenditure incurred**

The average expenditure incurred by patients before LTMGH was Rs.2533 (Mean) or Rs.700 (Median) - Table 19. This includes expenditure incurred as out-patients in LTMGH too. Slightly more than half the patients spent less than Rs.1000 (including the seven patients - or 8.7% - who spent nothing). The remaining incurred expenditure in a wide range that went up as high as Rs.20,000. The twelve patients (or 15.2%) who spent more than Rs.5000 notched up an average expenditure of Rs.10,591.70. This is a

stupendous sum given their (and their family's) earning capacity. Most of this expenditure was incurred in the private sector.

## **2.4 Familiarity with LTMGH**

As many as 84 out of 120 in-patients (70%) were first timers with no previous experience of indoor care in hospital. The hospital's appeal obviously transcends local boundaries and encompasses the entire metropolis. This is perhaps the expected function of a tertiary facility.

However, what is interesting is the relative unfamiliarity of these new patients with indoor care in other public hospitals. To begin, only 20.3% of all patients were previously treated in other BMC or government-run hospitals - Table 20. This low proportion was further lowered in the case of these new patients. Therefore, most patients were not habitual users of public services (or public services in the city at any rate).

Under these circumstances, did they seek personal contacts in hospital? Here again, the proportion of patients who were helped by some member of the staff with whom they were acquainted was a mere 16.3% - Table 20. This proportion comes further down in the case of newcomers.

## **2.5 Reasons for coming to LTMGH**

Why did patients come to LTMGH? The motivations that guide patients are important as they obliquely provide information about the question of expectations and consequently satisfaction. The information presented in Table 21 is actually a combination of answers received to two questions in the interview schedule, namely, "*What was your opinion of about the hospital before coming here?*" and "*Considering there are so many other hospitals you could have gone to, what made you come to this hospital for treatment?*". The reason is that the two responses were usually the same.

There were two major reasons why patients came to LTMGH for in-door care. The first was founded on the belief that the hospital was a good one or certainly a large enough one to ensure access to supportive facilities. More than half the patients (ie.51.6%) singled out this reason for special mention. This perception dominated the decision making of patients who were hospital regulars (certainly those who had some experience of the hospital) and those who lived in Mumbai: 77.8% of the former and 57% of the latter considered the hospital to be good.

The second factor that brought 40.2% of all patients was referrals. Referrals were particularly indicated in the case of those who had no previous experience with the hospital (50%) and those who lived outside Mumbai (55.6%).

Practical considerations such as the hospital's proximity and financial accessibility were also mentioned by 23% and 18% of all patients respectively. The advantage of proximity was particularly appealing to residents of Mumbai who had previous contact with the

hospital while the question of financial accessibility motivated those who were newcomers to hospital.

### **3. EXPERIENCE OF INDOOR CARE AT LTMGH**

#### **3.1 Gaining Access**

Were the patients in our study daunted by the procedures before admission? Did they encounter unnecessary delays in the process of form filling? Was there a delay in the allocation of a bed? Table 22 summarises this experience. Accordingly, 88.3% of all patients perceived no problems while seeking admission in the ward nor delays in the process of registration or form filling. However, 20.8% reported delays in being assigned a bed while 19.2% reported some difficulty in getting information about the procedures to be followed.

#### **3.2 Quality and Adequacy of Physical Facilities**

Tables 23 and 24 present data on physical facilities provided by the hospital. Information for the former has been derived from a questionnaire circulated to sisters-in-charge of the wards while the latter has been gleaned from the patient-interview.

The availability of physical facilities, as listed in Table 23, is determined as much by their supply at any given time as by their wear and tear. The bed sheets, pillow covers, blankets, towels and clothes sent to the laundry or discarded; the bedpans, urine pots, spittoons, lockers, stools, stretchers and wheelchairs sent for repair are immediately brought into the picture. Therefore, the *availability* of physical facilities is more sensitive to the patients' situation than *supply*. Ultimately the availability of facilities determines how these will be *used*. These three aspects, namely *supply*, *availability* and *use* of certain physical facilities at the ward level have been analytically presented in Table 23 as ratios to the number of patients and beds.

At the time at which the questionnaire was filled up, hospital admissions were below its bed capacity. Therefore the availability of facilities per patient was better than availability per bed.

On the whole, the per-patient and per-bed availability of mattresses, towels, bed sheets and pillow covers was greater than one. However, the per-bed availability of blankets and bedside tables or lockers was less than one. The other facilities distinctly in short supply were bed pans, urine pots and spittoons. With ratios of one to 0.28, 0.38 and 0.45 respectively, at least one out of two patients were made to do without them. In comparison, stools were available to a somewhat larger extent per patient and per bed but it was still a long way from becoming universally available to all patients and indeed to all beds. Stretchers, wheel chairs and oxygen cylinders - the three supportive facilities in each ward - were supplied and available at the rate of 1:10 patients on average.

The table showed no great differences between the numbers of facilities supplied and available. There were two notable exceptions though - bed sheets and towels. For despite more than seven bed sheets being supplied by the hospital per patient, the number actually available was less than three. The supply and availability position vis-à-vis beds were slightly over six and three respectively. Similarly, from a supply position of more than two towels per patient (and bed), the number available was less than one in both cases. Here, the hospital's laundry and the policy towards replacement of worn out stock needs to be assessed. Some of the wards reported that sheets that had been given for cleaning had not been replaced for more than three months!

Data on facilities in use per patient is largely reflective of data on availability. However, the surprising finding is those bed pans, urine pots and spittoons that are already well below patients' requirements were further rationed by the ward managers.

The last finding in Table 23 pertains to the allocation of physical facilities to the wards and it is here that the problem of maldistribution becomes glaringly visible for *all* facilities (except bed sheets). This is a significant finding to say the least. Differential utilisation patterns partly account for this: at the time at which the questionnaire was filled by the sisters-in-charge, 41.2% of the wards showed admissions in excess of beds. However, an inflexible management must also be seen as contributing to the present scenario. It is from such a background that the experiences of patients in the wards stem.

Besides the management of facilities, the physical structure of the wards itself is important. The study has been able to elicit patients' responses about the cleanliness and noisiness of wards. Most patients perceived the wards to be clean (101 out of 123 or 82.1%) and 98 (out of 123 or 79.7%) believed that the noise levels were not unduly high or disturbing. A few had specific complaints about the wards that will be dealt with in the next section.

The physical facilities included in the analysis are hospital beds; bed linen (namely, bed sheets, pillow covers and sheet for covering) and hospital clothes. Specifically, the study elicits responses on the provision and cleaning/changing pattern of linen and clothes. In addition, the study captures patients' perceptions about the adequacy and quality of food and drinking water.

Table 24 shows that beds, linen and clothes were not routinely provided to all patients after admission. The proportions of those not provided with these facilities were 3.2% (beds), 19.5% (linen) and 16.3% (clothes). These are significant findings. At the other end of the scale were those who were provided these facilities immediately after admission: 66.7% (bed), 55.3% (linen) and 71.5% (clothes). Lying between these two extremes were patients who were provided facilities after some delay. Here the data on time is confounded by fairly large proportions of no responses: 23.6% (in the case of facilities for sleeping), 11.4% (in the case of linen) and 4.1% (in the case of hospital clothes). We have made some attempt to present information on delayed provision as proportions of total hospital stay (in Table 24). This provide interesting but not significant details since the numbers are small.



Once provided, how often are linen and clothes changed? Table 24 shows that 21.1% of the linen and 27.6% of the hospital clothes had never been changed until the time of the interview. The proportion of patients whose linen and clothes were changed daily was 13.8% and 4.9% respectively. This is reflective of the virtual absence of reserve stock of bed sheets and pillow covers in the wards. Since the study fails to get similar ward-level information about clothes, it is not possible to place that finding in its proper context.

The study has generated information about the quality of hospital clothes (but not of linen and bed). This was observed by our interviewers. Torn and ill-fitting clothes with missing accompaniments (like buttons and *nadi*) were grouped under the label of poor quality. In this context, it is interesting that as many as 59.3% of the clothes provided by the hospital were of poor quality. Only 13% were certified by our interviewers as being good.

The experience of living in a hospital ward can never be complete without food and drinking water. This is where subjectivity is at its highest. Thirty out of 123 patients were eating food brought specially from their homes. So it has not been possible to get their perceptions about the quality and adequacy of hospital food. Of the 93 patients who were actually eating hospital food, less than half (or 47.3%) approved of it. On the other hand, 37.6% labelled it as being tolerably good and 9.7% thought it was positively bad. The data on adequacy is somewhat better since 77.4% felt that the food was sufficient.

Similarly, 78% (or 96 out of 123) patients were satisfied that clean drinking water was being provided to them without their having to ask for it. Roughly one in ten patients (or 9.8%) reported that water was provided when they asked for it.

The experience of adequacy and shortage as well as quality of physical facilities is subjectively translated into various shades of satisfaction. We will come to this in the next section.

### **3.3 Inter-personal relations**

Integral to the treatment process in institutions (like hospitals) is the quality of the relationship between patients and their caretakers. These are not merely doctors and nurses but wardboys and ayahs who provide vital service. Do patients gain access to the medical and scientific expertise of doctors and nurses or do they succeed in getting assurance and information on their illness? How do patients perceive and receive medical attention? These are the more intangible aspects of the curing process (and therefore satisfaction) which we have tried to capture in the present study. However, the quantitative methodology and the tightly structured interview schedule impose severe limitations on the scope and quality of information. Tables 25 to 28 present information that has been generated by the study.

Table 25 touches upon the availability of personnel like nurses, ayahs, wardboys, and sweepers. These personnel are assigned to specific wards. Again this information has been culled out from the questionnaire filled by the Sisters-in-charge. The table presents average ratios of patients per staff member. These ratios have been calculated for the numbers of personnel sanctioned, appointed and available on a particular day. Out of

these, availability ratios are most appropriate from the point of view of patients. These are approximately 1:5 patients (for nurses), 1:12 patients (for ayahs), 1:11 patients (for wardboys) and 1:8 patients (for sweepers). However, even these ratios do not truly represent availability since the unit of time is a *day* and not a *shift* (which is a better indicator). As a result, some of the caring functions that nurses are unable to render have to be taken on by relatives. This fact has not received adequate recognition.

Unlike nurses and the other staff who are assigned to wards, doctors (including Resident Doctors, Lecturers and Honorary Consultants) are assigned to departments. Unfortunately, it is not possible to calculate ratios for doctors at this stage nor even assess the quantum of time per patient. We do, however, have some response about the information that patients receive about their illness. This is shown in Table 26.

Two thirds of all patients said that they got information about their illness (either of the doctors' accord or when they asked them) and were able to understand it. Significantly, 13% were unable to understand information and 17.1% did not get information at all. Since these responses were elicited through a highly structured questionnaire, they tell us nothing about the scope and depth of the discussions that take place between doctors and patients and the questions asked by them.

It is clear, however, that patients are uncritical about doctors and nurses. When asked about whether they believed these two caretakers to be competent, an astoundingly large proportion of 88.6% believed that all doctors were competent while a larger proportion of 91.9% believed that all nurses were competent - Table 27. This appreciation is also extended to their behaviour: 90.4% listed positive attributes while describing the doctors' behaviour (good, polite, helpful, kind, patient, etc.) and 94.3% did the same for nurses - Table 28. The overarching emotion was one of gratitude for receiving such expert care. One of the patients who was rushed to LTMGH after being injured in a fight was touched that the doctors at the Operation Theatre spent time over him at the cost of their lunch. This is a highly dramatised account occasioned no doubt by somewhat extraordinary circumstances but it does serve to show the awe with which patients hold doctors in hospital.

However, one of the patients who was referred from the Mathadi Hospital for an eye complaint was peeved that the regular doctors never took the time to visit him while students routinely "poked him in the eye" and left without telling him anything. Whether this is an isolated experience or a common complaint we will never know since the study overlooked this aspect. In retrospect, this lapse is unfortunate.

Patients also come across *ayahs* and wardboys. Since considerations about time prevented us from engaging in a full fledged discussion on the manner in which they conducted their duties, we could only ask a few pointed questions about their behaviour. Here the trend reverses dramatically. As shown in Table 28, the proportion of patients who felt that the behaviour of wardboys and *ayahs* was positive was 50.4% and 48.8% respectively. On the other hand, the numbers who were unwilling to comment were great : 49 (or 39.8%) in the case of wardboys and 46 (or 37.4%) in the case of *ayahs*.

Therefore, patients showed greater intolerance towards Class IV employees who probably came from the same social class as themselves.

### **3.4 Medical Facilities**

The process and outcomes of medical care undoubtedly have some bearing on satisfaction. However, it is clearly beyond the scope of the present study. From the patients' point of view, the provision of drugs and facilities for diagnostic tests and the attendant expenditure have been considered. This is presented in Table 29.

The study clearly shows that patients have to bear the brunt of inadequate provision. As against 24 patients (or 19.5%) who were provided all medicines by the hospital, an overwhelmingly large proportion of 68.1% came face to face with shortages that had to be compensated for by purchases from outside pharmacies. The situation vis-à-vis diagnostic tests is much better. Nearly two out of three (or 64.2%) were able to get all the required diagnostic tests done at the hospital.

Arising out shortages in "medical facilities" were expenditures which patients had to make. The average expenditure incurred by patients on medicines was Rs.802.93 (when calculated as a mean) and Rs.200.00 (when calculated as a median) - Table 29. Similarly, the average expenditure incurred by patients on diagnostic tests was Rs.721.61 (when calculated as a mean) and zero (when computed as a median).

Table 29 shows that except for a few, most patients had to incur some expenditure for medical facilities. This is so even if provision by the hospital is complete: while it is true that the median expenditure for these patients is zero, the mean expenditures were Rs.327.38 (medicines) and Rs.330.49 (diagnostic tests) respectively. These sums shot up in the case of those who had to approach external agencies for medicines or tests. For medicines, this expenditure was Rs.1052.22 (mean) and Rs.300 (median) and for tests, this was Rs.3217.06 (mean) and Rs.500 (median).

The differences in expenditure between the median and the mean can be accounted for by the widely varying market prices of drugs and diagnostic tests and by the prescription practises in the different departments. Table 30 shows that there were wide variations in the expenditure incurred in the different departments. The wards in which the range of expenditure for medicines was widest were Orthopaedics and Urology. The wards in which the range of expenditure for tests was widest were Surgery, Medicine, CVTS and Neurosurgery.

### **3.5 Expenditure in LTMGH**

The total expenditure incurred by patients after admission fell into a wide range from zero to Rs.32,000. The average expenditure was Rs.1555.4 (when calculated as a mean) and Rs.400 (when calculated as a median). It is obvious that there are extreme values that are distorting the computation of this average figure. Indeed, the finding that more than half the patients spent no more than Rs.500 would add credence to this argument. However, to accept the median as a more credible figure would essentially mean

accepting that the patients (specially the 16%) incurring substantial expenditures in excess of Rs.2000 is inconsequential to the analysis. This assumption is unacceptable.

Table 33 shows that, on an average, expenditure on medicines accounted for 69.7% of the total expenditure in hospital while diagnostic tests accounted for 26.1% and bed rent made up 2.7%.

One should not take the above figures too literally. The reason is that the computation does not truly capture expenditure. Firstly, it records expenditure incurred until the time of the interview and not till the time that patients are discharged. Secondly, in including only direct costs on medicines, tests and bed rent, it fails to cover the range of non-medical and social expenditure that invariably goes with hospitalisation. This includes the loss of wages for patients and the relatives accompanying them, transport and food costs for relatives, bribes and tips, etc. The study of expenditure is an entirely separate exercise. For the time being, it is sufficient to say that expenditure data presented in Table 31 is really an underestimation of real costs.

To overcome this limitation, we have considered a *day* (rather than the period of admission) as an indicative period and compared daily expenditure with daily household income. The results are presented in Table 32. Taken as a whole, it is obvious that per day expenditure at LTMGH (which ranges from zero to Rs.2600) far exceeds per day household income. The mean expenditure was Rs.215.2 even as the mean income was less than half (that is, Rs.91.7). As many as 41.8% of all patients spent more on hospital care per day than their households earned. When expenditure is computed as a proportion of income, an average figure of 329.2% presents itself. This is a startling revelation that cannot be taken lightly specially when you consider the economic class from which patients come. The table shows that any expenditure over Rs.100 per day has far reaching implications for the patients' household economy.

#### **4. SATISFACTION**

We now come to that subjective evaluation of indoor care called *satisfaction*. Satisfaction is linked to expectations. What these are have somewhat briefly been touched upon in a previous section: the hospital's size ("big hospital") and, to a smaller extent, its vicinity and financial accessibility have been quoted. Thus patients have alluded to the hospital's accessibility but beyond that, there is no specific charter of demands in evidence at all. Somehow the recognition that they have a right to expect certain services, on the whole, does not exist. Perhaps this should come as no surprise when you consider their class background.

To convert this subjective frame of mind into a quantifiable form, we asked patients to grade their "satisfaction" into three categories: Fully Satisfied, Partly Satisfied and Not Satisfied to which we assigned scores of 3, 2 and 1 respectively. Non-responders were excluded from the analysis while patients who were willing but unable to opine (the "Cannot Say-ers") were assigned no score. Finally, average (i.e. mean) scores were computed and the sample divided into two: those with below average scores and those with above average scores. This exercise was done for each of the components of indoor

care. Finally, a composite score for overall satisfaction was created by bringing into the computation, all the individual scores of satisfaction. Here again, patients not responding to even one of the categories of care were excluded from the analysis. This was a large number: 50 out of 123 or 40.7%.

Satisfaction scores are presented in Table 34. It bears testimony to the fact that patients were very satisfied with their experience of indoor care in hospital. On a scale of 0-3, most scores exceed 2.5; even the composite score is as high as 2.65. Within the normative framework so defined, there are shades of opinion to be found. Thus 39.7% recorded below average satisfaction while 60.3% recorded above average scores.

Table 39 pitches overall satisfaction scores against each of the departments covered by the study. The four most populated departments showed interesting trends. Thus, while as many as 85.7% of the patients expressed a high degree of satisfaction in the Obstetric and Gynaecological departments and 92.3% did too in the department of Surgery, the proportions of patients with above average satisfaction scores in the Medicine and Orthopaedic departments were 50% and 14.3% respectively. These are interesting findings. However, given the small numbers, it would not be right to place too great an emphasis on them.

Similarly, Table 37 correlates satisfaction with socio-economic indicators. The only variables that showed some marginal association were education and "access". Thus, rising educational levels got increasingly translated into above average satisfaction. However, the correlation coefficient (in this case, Goodman and Kruskal's Gama  $\gamma = 0.3145$ ) shows low association between the two variables which is statistically significant.

Similarly, being acquainted and helped by staff of the hospital had a negative influence on overall satisfaction. However, the correlation coefficient (in this case Phi coefficient  $\phi = 0.3505$ ) shows low association which is not even statistically significant.

The other variables considered (namely sex, economic role, daily expenditure, familiarity and duration of stay in hospital) show neither association nor statistical significance.

#### **4.1 Satisfaction with physical facilities**

Patients' satisfaction with physical facilities like the hospital ward (2.82), toilets in the ward (2.71) and sleeping facility (2.78) were very high - Table 34. The proportion of patients who tended to show below average satisfaction with the hospital ward and its sleeping facility was 17.6% and 19.8% respectively - that is, nearly one in five. On the other hand, patients expressing below average satisfaction about the toilets in the wards were roughly in the ratio of 1:4 (or 23.1%).

The average satisfaction scores for physical facilities like linen (2.47), clothes (2.22) and food (2.40) were lower than all the other scores in Table 34. Further, the proportions with below average scores were also significantly more: 35.3% (linen), 51.8% (clothes) and food (46.1%). These are substantial proportions by any standard.

Further analysis shows possible association between satisfaction and timeliness of provision (categorised as "immediate provision", "delayed provision" and "no provision"). As shown in Table 38, the proportion of patients with above average scores was highest when provision was immediate. These proportions shrunk as delays were encountered or as facilities eluded patients. This is evident in the case of the hospital's beds, linen and, to some extent, clothes. In the case of clothes, the swinging of opinion appeared to take place in response to quality: the proportion of patients with above average satisfaction was as high as 90% when quality was good. This proportion plummeted to 36.1% when quality was poor and rose slightly to 41.7% when clothes were not provided at all. However, we cannot show any of these relationships statistically.

#### **4.2 Satisfaction with health workers**

That patients were extremely gratified with the medical staff is obvious from one look at the average scores: 2.93 for doctors and 2.92 for nurses. Almost all patients professed above average satisfaction with them: the proportions registering below average satisfaction were 5.9% (doctors) and 7.6% (nurses). However the situation is somewhat different in the case of wardboys and *ayahs*. Although the average satisfaction scores for these two categories of personnel are 2.76 and 2.72 respectively, one in five patients were on the wrong side of these scores. The proportions registering below average satisfaction were 22% (for wardboys) and 22.6% (for ayahs). Equally significant is the fact that 18.7% of the patients were unwilling to opine about wardboys and their satisfaction with them.

#### **4.3 Reasons for Satisfaction**

Two major factors contributed to patients' satisfaction with LTMGH: the hospital's staff and its facilities - Table 35. One third of all patients were satisfied with the prompt attendance of the staff, their behaviour and their good service. This consideration was particularly reassuring to 58.6% of those whose satisfaction scores were below average. On the other hand, 28.5% of all patients perceived the hospital and its facilities as being good. This was particularly appealing to 34.1% of those whose satisfaction scores were above average.

Satisfaction stemming from favourable outcomes of hospitalisation (namely, recovery or "feeling better") was evident in the case of 18.7% of all patients. Again, this was viewed as a redeeming factor by 17.2% of those whose satisfaction scores were below average. Similarly, the more pragmatic reasons for satisfaction like the "free" treatment offered and the hospital's proximity to home were mentioned to some extent by all patients but particularly those with below average scores.

These are interesting findings. More significant, however, are the large numbers of non-reponses. Nearly one third of all patients (30.9%) but specially 43.2% of those with above average satisfaction scores offered no explanation! Far from being null responses, these proportions are high on interpretive value.

They signify satisfaction bordering on indifference. Equally, they signify satisfaction rooted in ambiguity. Both are not unexpected responses when you consider the looming presence of the hospital in the patients' lives and their inconclusive experience in it. Patients were obviously unable to take a dispassionate look at their stay at LTMGH. If they were interviewed later, they would probably have reacted quite differently to our question on satisfaction.

Given the high levels of satisfaction expressed by patients in our sample, dissatisfaction was incoherently uttered. Here again, we are put up against non-responses going up to 20.7% among those with below average scores. The only palpable cause of discontent was the non-availability or poor quality of facilities. To this can be added a motely group of reasons presently grouped under the label "Any other" like shortage induced delays, insufficiency of wardboys and being charged for facilities (like airconditioning in the ICCU) that do not work.

#### **4.4 Patients' Charter of Recommendations**

What improvements would patients like to see in the hospital? When asked this question, a substantial proportion of 46.3% wanted better living conditions in the ward in terms of better physical layout and facilities - Table 36. The list of individual suggestions read like this:

- a) Water to be provided for 24 hours, hot water to be provided for bath;
- b) Toilets (including door latches) to be repaired and cleaned;
- c) Beds instead of mattresses on the floor to be provided;
- d) Windows to have curtains;
- e) More space to be created between beds;
- f) More stools to be provided;
- g) More fans to be provided as the present numbers were insufficient in summer;
- h) Television, radio to be provided for recreation;
- i) Clothes and linen to be cleaner and better in quality;
- j) Good/tasty and sufficient food to be provided. Hospital to supply chappatis instead of bread;
- k) Ward cleaning to be improved.

This articulate group co-existed with the group of patients (comprising 39% of the sample) who were unable to offer any comment.

## Conclusions and Recommendations

The commitment to improving quality of health care in a tertiary level hospital like LTMGH is laudable. However, the institution of tools to ascertain quality, the creation of an environment conducive to quality assurance and most importantly, the will and resources necessary to implement such objectives are very daunting. If undertaken systematically and regularly, research could be a very useful tool in identifying areas of improvement and in providing concrete suggestions for the practical ways to do that. Compared to such need, our research is only a beginning, a prelude to more systematic work in time to come provided, of course, that the hospital would like to be a part of such a research programme.

We have not been able to identify good and reliable studies with which we can compare the methodology and findings of the present study. This glaring absence of data on quality must be rectified at the earliest. The purpose of research on quality is not to occasionally reassure the hospital's management that all is well. Rather it is a continuous process for improvement and for sensitising the services to the real needs of people. Given the present state of our hospitals, both public and private, we indeed are very anxious that this study does not become a piece of decoration in libraries and offices. While good research is always accompanied by academic laurels, it should additionally and necessarily contribute to meeting people's need: in the present case, their need for good quality medical care in public hospitals.

There are three follow-up requirements for this study to make such a contribution: first, the findings of this study may be discussed by the concerned individuals in hospital and the Municipal administration with total commitment to improving the quality of care in public hospitals; second, a long-term research programme may be drawn up for quality assurance and for making necessary changes in the health policies in Mumbai; and last, a mechanism may be put in place to implement various measures for improvement in the quality of health care.

### **Shrinking social base:**

The historical contribution of public hospitals of Mumbai in setting high standards of medical education and medical care is indisputable. Their genesis show that these hospitals combined voluntary private initiative, philanthropy, social commitment and nationalist spirit in the preindependence period and for some time after that. The very fact that they embodied excellence made them centres of attraction for doctors and patients alike. This provided them with a wide social base: the cross section of people using them expecting better services and those providing it responding to people's expectations. While these hospitals still produce doctors who practise medicine, more so in the city, the popular perception and expectations of the quality of care in public hospitals has undergone a sea change. Indeed, even many providers working at the public hospital do not believe that their service is of adequate quality and some of them appeared to be resigned to this state of affairs.



One of the process of quality improvement is centred on user-provider interaction. To an extent when the user asks for better services, a pressure and demand for improvement is created. Such user demand, as we found from the study, is absent, or at the best, very low key. An apparent reason is the shrinking social base of the public hospitals. As the findings show, the middle classes, who are normally vociferous in demanding better services, have virtually abandoned public hospitals. The hospital's users are the poor who show a preference for private providers in the first instance and who come to public hospitals only when they experience no improvement in their condition or when they have exhausted their money. Thus, the poor who are now the predominant users of the public hospitals, also seem to have a diminished attraction for the public hospitals. By the time they come to hospital, they are grateful for whatever care comes their way. Consequently, their expectations are low. This in turn fails to generate direct pressure on the institution for improvement.

The assumption that public hospitals are meant only for the poor would be detrimental to them in long term. For such an attitude would lead to their ultimate abandonment without the creation of any alternative. This will put the large section of the poor who need public hospitals but may be disinclined to use them (due to their negative public image and indifferent quality) at a considerable disadvantage. Surrounded by a plethora of private institutions, public hospitals that serve the poor cannot but get pressured by competition with the private sector. A conscious effort is thus needed at two levels:

First, although public hospitals in Mumbai have been remarkable in providing numerous areas of care and imparting good medical education, little has been done to document the excellent work of many departments and even less has been done to publicise such information. Often only negative information is brought to public notice by the media while the hospitals have felt shy to "trumpet" their achievements. For instance, the rate of caesarean section deliveries is significantly and rightly low in public hospitals as compared to the private ones. The latter indeed are practising irrational and harmful obstetrics. Yet, the public hospitals have failed to bring out their data to educate the public and take lead in reforming the private maternity homes. Unless that is done, the irrational and harmful practices followed by others would be considered good medicine by users, and they would start demanding the same from public hospitals. Use of excessive injections, irrational therapeutics, unnecessary investigations, etc. by the profit oriented private sector are other examples where the public hospitals could play a very important educative role and regain its leadership status.

The second level is to make conscious effort to improve the quality, irrespective of whether the users are actually demanding it or not. This means that the commitment to quality is made a part of the culture and tradition of the hospital. In the absence of strong pressure from the users demanding high quality, a vicious circle sets in which leads to low quality, alienation of larger strata of people and again lower demand. This circle could be broken by the administration only by making conscious organised efforts to continuously improve quality.

### **Improving access through strengthening of peripheral public health care:**

The tertiary public hospital is at the apex of the wider infrastructure of the public health care system. Its base is in the health posts in the slums and the dispensaries. However, there is a clear-cut evidence from the findings that this base is weak and not functioning in the way they should. A significant proportion of patients seem to use the hospital OPD as first contact service, and another big section approaches the hospital via private practitioners or nursing homes.

There are two consequences of such process. Firstly, the specialised departments of the hospitals in their OPDs are overloaded with patients suffering from simple complaints which could be tackled at the dispensaries and satellite hospitals. This eats into the time given to those genuinely needing specialised consultation. Secondly, since many patients travel to the public hospital after spending lots of their hard earned money, a tendency to *victim blame* surfaces. That is why it not unusual to hear that, “if they could spend money at the private nursing home, why not make them pay for various services provided in the hospital?” Thus, a patient thoroughly exploited by the private sector is further impoverished at the public hospital. This has led to the desensitisation of many of the public hospital staffers to the financial constraints of those who utilise their services.

Thus, the basic structural and policy issue of strengthening the peripheral units needs to be addressed. Effectiveness of a well organised health care service is a function of good primary care facility at the health post and dispensaries and of good care at the satellite hospitals providing secondary care. The tertiary care institutions like the LTMG would function better if they are strictly used as referral centres and not as centres providing direct care at all levels. Thus, improvement in the quality of care at the LTMG hospital, in the long run, is contingent upon the improved quality of care at the primary and secondary levels. A simple study of the way such units are spread, the pattern of their utilisation, the nature and quality of services provided, the ways in which they could be improved, etc. is urgently needed.

### **Improving Private Sector Health Care:**

Half of the patients had first approached private practitioners, and of all the practitioners approached before getting admitted at LTMGH, almost 75% were private practitioners. Further, nearly three out of five patients were ill for more than three weeks before coming to hospital. Thus, for a long duration, the patients kept on changing providers, particularly providers in the private sector, before approaching the hospital. From the findings it is also clear that the reason for such long duration of treatment was ineffective treatment and delayed referral. This only shows that the care provided by private doctors is inadequate or irrational. A significant amount of misdiagnosis is indicated and referrals deliberately delayed until patients have been squeezed dry cannot be ruled out.

In all such cases not only do poor people get exploited, but public hospitals, which cater to patients who seek tertiary care at a late stage, are faced with increased costs of care. Thus, public hospitals end up spending more due to faulty medical practice by private doctors and nursing homes. Since the Municipal Corporation is the regulatory body for

private hospitals and nursing homes and since government representatives sit on the medical council which govern the practice of private doctors, it is necessary for public hospitals to take the initiative in making the private sector accountable for substandard care provided to such patients. A positive and constructive way of beginning this process would be by organising continuing medical education of doctors at public hospitals and in that process, develop standards of care expected from private practitioners and nursing homes. Certain protocols for referral from the private sector to public sector could be worked out so that the doctors and nursing homes in the private sector that violate them could be made accountable. This way, the public hospitals may be able to contribute in improving standard of care in the private sector and at the same time establish some necessary regulations over the private sector.

There is another area of referrals from the private sector, particularly from the nursing homes, that needs to be brought under regulation. That is the late referral of critically ill patients. It is observed that the nursing homes sometimes retain patients (even when they do not have the means or the expertise to treat such conditions) and refer them to public hospitals only when their condition deteriorates or they become critically ill or they cannot pay for care anymore. These bad practices in the private sector contribute to increasing the cost of care in public hospitals. There is a need for a comprehensive study on the extra cost being borne by public hospitals in such situations and appropriate regulatory mechanisms to make such private hospitals accountable.

A lesson to be learnt by those who are advocating mindless privatisation of the public hospitals is that the conditions in the private health sector is far from satisfactory, so much so that in the absence of public hospitals cleaning the mess created there, the suffering of the patients would only multiply.

### **Cost of Medical Care:**

While our study was not specifically designed to understand the cost of medical care, we made sincere efforts to get preliminary idea on how much patients spent on medical care. The data obtained on costs are therefore under-estimations. Even so, the data raises many important issues.

The amount spent by patients before and after getting admitted at LTMGH is very high. As compared to an average monthly household income of Rs.2,749 per month, patients spent, on an average, Rs.2,533 before and Rs.1,555 after the admission. Since these patients were still under treatment at the hospital, they would have spent more before getting discharged. Thus, on the date of the interview, on an average, one and half times the monthly income of the entire household was already consumed only in medicines, investigations and doctors' fees. This ratio would have been twice as high by the time they were discharged.

This only shows that the inadequate supply at the public hospitals is making the poor people poorer, perhaps some of them getting into debt trap or others forced to sell their assets. Such a situation only creates a vicious circle of poverty-illness-poverty. Any policy that attempts to introduce or increase the financial burden on patients who access

public hospitals for medical care would not only be highly detrimental but unethical too. Further, this situation also draws attention to the fact that a big majority of patients admitted in the public hospitals need financial assistance. It might therefore be wiser to make the social workers, who are at present assigned job to raise funds for the needy patients referred to them by doctors, to take regular round of all patients to find out their economic needs and to arrange for assistance for the needy patients from philanthropic organisations or individuals. This could be done by assigning social workers directly to wards and by giving them some authority to decide about the needy patients. The role of overburdened doctors in it could be limited to proving a certificate of the quantum of medical needs.

At the same time measures are needed to reduce the financial burden on the patients. Our data show that such burden is coming primarily to meet two requirements, medicines and investigations. Before any simplistic suggestion is made to increase the budget for these two items it is necessary to assess that the present budget is used appropriately. A study of drug utilisation at district hospital and primary health centres in Satara district has shown that a significant proportion of drugs supplied to these units and of drugs prescribed by doctors from outside, are irrational combination drugs or are unnecessary. Thus, an audit of the drug supply and prescriptions must be undertaken to find out ways to better utilise the existing resources. Similarly an audit of investigations carried out at the hospitals and those carried out elsewhere must be undertaken to understand the efficiency with which the hospital resources are utilised, the number of days for which particular investigations were not done at the hospitals and their reasons etc.

#### **Improvements in hospital management:**

A number of managerial issues needing urgent attention could be identified from the findings of the study. Some of them are as follows:

**Department-wise bed distribution:** Clearly, the bed utilisation of some of the departments is higher than others. As a consequence, some departments are over-crowded while the other are grossly under-utilised. This of course was the situation at the time of the study. A quick retrospective study of department-wise bed utilisation for last three years is indicated. From the data it appears that some flexibility in bed allocation to different department keeping in mind the demand in different seasons may be required. A managerial solution to the difference in bed utilisation is arrived at, it would go a long way in providing better services and in improving patient satisfaction.

**Sex-wise bed distribution:** The sex-wise bed distribution is the most skewed of all at the LTMG hospital. On face of it the data shows that one third of all beds (420 out of 1278) are for female patients. However, of the 420 female beds, 200 (48%) are in the obstetric and gynaecology (O&G) wards. Since these beds are very specific to women's needs which are to an extent over and above the other medical care needs of women, they should have equal share of beds in the non-O&G wards. However, their share of beds in the non O&G wards is only 20.4% (220 out of 1078). This is a grossly low allocation of beds for female patients. This is also one of the reason why normally all the female non-O&G wards are over-crowded in all public hospitals of ours. This could also be one of

the reasons for the under-utilisation of hospital facilities by women. Given such skewed bed distribution, one needs to probe the differentials in the quality of care provided to women.

An immediate measure needed is increase in number of non-O&G beds for female patients in the LTMG hospital. This must be done without reducing the present O&G beds. Our study did not try to find out the adequacy of the O&G beds and so we are not in a position to make any comment on it.

**Facilities in the ward:** We have study the supply, availability and use of items such as beds, mattresses, bed sheets, pillow covers, blankets, hospital clothes, bed pans, urine pots, spittoons etc. The data shows that some items are supplied in ample quantity while others are not. Besides, in some cases, even after supply has been adequate, the actual availability and use have been lower simply because of loss or damage to items, bad and inefficient maintenance (e.g. laundry, repair) or because of the reluctance of the ward managers to bring the available items in use (who seemed to have kept some of the items in lockers for the reasons not known to us). On the other hand, the patients have complained against the quality of food. Unfortunately we did not have time to inspect the food and to find out reasons for such complaints. But there is a strong case to look into the matter so that the quality of food supplied by the hospital is improved.

Needless to add, the small items constituting physical facilities provided to patients in the ward make greater contribution in determining patient satisfaction. There is an urgent need to thoroughly investigate the way these items are managed in the hospitals and wards and to take immediate measures for improvement.

**Medical and Nursing personnel for the ward:** Since we could not study the availability of medical personnel - from senior doctors to the house-staff - in the wards, an assessment of that is needed. Particular attention needs to be paid to the role played by the full-time staff and to the honoraries. One must also examine the behaviour of medical students with patients and the use of patients for clinical studies and classes.

The availability of nursing personnel in the ward appears to be less that required. In such a situation it is likely that some of the traditional primary nursing functions are delegated to the non-nursing lower level staff like *ayas* and ward boys, who in turn are not having requisite training and sensitivity to patients' needs. A comprehensive understanding of the nursing requirement of patients and the role assigned to various categories of staff are indicated.

It should be noted though that the patient satisfaction for the behaviour of doctors and nurses have been high. However, such satisfactory response cannot be taken at the face value as the patients are not made aware of what exactly to expect from them.

**Ward-boys and *ayas*:** Many patients have expressed dissatisfaction or not responded to our queries on these two sets of workers. We had not asked questions to them on the work of sweepers. Undoubtedly improvements in their work and behaviour are indicated. We feel that in order to actually achieve something long term with them it would be

necessary to understand their role, both in the ward management and patient care, their status vis-à-vis other workers and the manner in which their work is actually organised. Their socio-economic background, education, aptitude for work and above all their needs for improving their contribution in the work of hospital are the area of further study. It must be kept in mind that unless every one in the hospital is made to feel that he or she is contributing something in the patient care and that their contribution is valued, no administrative measure would be successful in achieving the improvement. Based on such understanding, some efforts at training and reorienting the staff in these categories should be undertaken.

**Quality of care and patient satisfaction:** While it is essential to assess patient satisfaction on regular basis, the satisfied patients do not necessarily mean the good quality of care in the hospital. As explained in the study, the satisfaction is generated by many factors, the good quality of care is not the only factor responsible. The findings of our study suggest that the very low socio-economic status of patients and the consequent low expectations from hospital by them have greatly influenced their response to the questions on satisfaction. Besides, these patients were still undergoing care at the hospital, their anxiety and vulnerability were also important contributory reasons shaping their responses. Further, in order to understand the way quality and satisfaction are defined by patient, the survey method used by us is inadequate. We would need qualitative methodological tools for such purpose. Thus, in order to understand patient satisfaction in a proper manner it is necessary that (a) this study is supplemented by a comprehensive exit survey/interview of patients, and (b) detailed qualitative studies, using case study and other methods, may be conducted.

## Section 5: TABLES

**TABLE 1: DIFFERENTIALS IN BED ALLOCATION**

Department	Total	Allocation of beds in the wards				
		Male Adults	Female Adults	Children (M,F)	Unclassified	Total
Obs. & Gyn.	200 (15.6)	-	200 (100)	-	-	200 (100)
Medicine	263 (20.6)	189 (71.9)	74 (28.1)	-	-	263 (100)
Surgery	223 (17.4)	144 (64.6)	51 (22.9)	28 (12.6)	-	223 (100)
Orthopaedics	121 (09.5)	73 (60.3)	38 (31.4)	10 (08.3)	-	121 (100)
Ophthalmology	44 (03.4)	31 (70.5)	13 (29.5)	-	-	44 (100)
Paediatric Surgery	10 (00.8)	-	-	10 (100)	-	10 (100)
Paediatrics	150 (11.7)	-	-	150 (100)	-	150 (100)
Neurosurgery	21 (01.6)	16 (76.2)	03 (14.3)	02 (09.5)	-	21 (100)
CVTS	20 (01.6)	14 (70.0)	02 (10.0)	02 (10.0)	02 (10.0)	20 (100)
ENT	44 (03.4)	32 (72.7)	12 (27.3)	-	-	44 (100)
Cardiology	34 (02.7)	15 (44.1)	05 (14.7)	-	14 (41.2)	34 (100)
Urology	24 (01.8)	21 (87.5)	03 (12.5)	-	-	24 (100)
AKD	14 (01.1)	-	-	-	14 (100)	14 (100)
Plastic Surgery	30 (02.3)	25 (83.3)	03 (10.0)	02 (06.7)	-	30 (100)
Respiratory	NA	NA	NA	NA	NA	NA
Skin	21 (01.6)	13 (61.9)	08 (38.1)	-	-	21 (100)
Gastroentology	NA	NA	NA	NA	NA	NA
<b>All departments</b>	<b>1278 (100)</b>	<b>588 (46.0)</b>	<b>420 (32.9)</b>	<b>204 (15.9)</b>	<b>66 (05.2)</b>	<b>1278 (100)</b>
<b>All departments (excluding Obs/Gyn)</b>	-	<b>588 (54.5)</b>	<b>220 (20.4)</b>	<b>204 (18.9)</b>	<b>66 (06.2)</b>	<b>1078 (100)</b>

Sources : Data compiled by the hospital's administrative office

**TABLE 2: GENDER DISTRIBUTION OF IN-PATIENTS IN DIFFERENT DEPARTMENTS**

Department	Gender Differentials per dept.			Number of patients and per cent			Sample as % of hospBed
	Male	Female	Total	Male	Female	Total	
Obs. & Gyn	-	27	27	-	27	27	13.5
		(100)	(100)		(57.4)	(22.0)	
Medicine	17	09	26	17	09	26	09.9
	(65.4)	(34.6)	(100)	(22.4)	(19.1)	(21.1)	
Surgery	18	02	20	18	02	20	09.0
	(90.0)	(10.0)	(100)	(23.7)	(04.3)	(16.3)	
Orthopaedics	07	04	11	07	04	11	09.1
	(63.3)	(36.4)	(100)	(09.2)	(08.5)	(08.9)	
Ophthalmology	05	03	08	05	03	08	18.2
	(62.5)	(37.5)	(100)	(06.6)	(06.4)	(06.5)	
Paed. Surgery	06	-	06	06	-	06	60.0
	(100)		(100)	(07.9)		(04.9)	
Paediatrics	04	01	05	04	01	05	03.3
	(80.0)	(20.0)	(100)	(05.3)	(02.1)	(04.1)	
Neurosurgery	04	-	04	04	-	04	19.0
	(100)		(100)	(05.3)		(03.3)	

CVTS	03 (100)	-	03 (100)	03 (03.9)	-	03 (02.4)	15.0
ENT	03 (100)	-	03 (100)	03 (03.9)	-	03 (02.4)	06.8
Cardiology	02 (100)	-	02 (100)	02 (02.6)	-	02 (01.6)	05.9
Urology	02 (100)	-	02 (100)	02 (02.6)	-	02 (01.6)	08.3
AKD	01 (100)	-	01 (100)	01 (01.3)	-	02 (00.8)	07.1
Plastic Surgery	-	01 (100)	01 (100)	-	01 (02.1)	01 (00.8)	03.3
Respiratory	01 (100)	-	01 (100)	01 (01.3)	-	01 (00.8)	NA
Skin	01 (100)	-	01 (100)	01 (01.3)	-	01 (00.8)	04.8
Gastroentrolology	01 (100)	-	01 (100)	01 (01.3)	-	01 (00.8)	NA
No response	01 (100)	-	01 (100)	01 (01.3)	-	01 (00.8)	
<b>All departments</b>	<b>76 (61.8)</b>	<b>47 (38.2)</b>	<b>123 (100)</b>	<b>76 (100)</b>	<b>47 (100)</b>	<b>123 (100)</b>	<b>09.6</b>

**TABLE 3: DURATION OF STAY IN THE HOSPITAL**

Department	Duration of Stay ( <i>in days</i> )					Average Duration	
	0 to 7	8-14	15-21	22-28	29+	Mean	Median
Obstetrics & gynaec.	18 (66.7)	08 (29.6)	-	01 (03.7)	-	06	05.0
Medicine	17 (65.4)	04 (15.4)	03 (11.5)	01 (03.8)	01 (03.8)	08	04.5
Surgery	12 (60.0)	03 (15.0)	-	04 (20.0)	01 (05.0)	10	06.0
Orthopaedics	04 (36.4)	03 (27.3)	02 (18.2)	01 (09.1)	01 (09.1)	13	09.0
Ophthalmology	02 (25.0)	02 (25.0)	02 (25.0)	01 (12.5)	01 (12.5)	15	13.5
Paediatrics	04 (80.0)	01 (20.0)	-	-	-	03	01.0
Paediatric Surgery	06 (100)	-	-	-	-	04	03.5
Neurosurgery	02 (50.0)	01 (25.0)	-	-	01 (25.0)	12	06.5
CVTS	-	01 (33.3)	01 (33.3)	-	01 (33.3)	17	15.0
ENT	02 (66.7)	-	-	-	01 (33.3)	13	04.0
Cardiology	02 (100)	-	-	-	-	04	03.5
Urology	01	-	-	-	01	26	25.0



AKD	(50.0)	01 (100)	-	-	(50.0)	13	-
Plastic Surgery	01 (100)	-	-	-	-	04	-
Respiratory	-	-	-	-	01 (100)	36	-
Skin	-	-	-	-	01 (100)	66	-
Gastroentrology	-	-	-	01 (100)	-	27	-
<b>All Departments</b>	<b>72 (58.5)</b>	<b>24 (19.5)</b>	<b>08 (06.5)</b>	<b>09 (07.3)</b>	<b>10 (08.1)</b>	<b>10</b>	<b>06</b>

**TABLE 4: AGE DISTRIBUTION**

Completed Age (in years)	Number and Per cent			Average Age of patients		No. & % female
	Males	Females	Total	Mean	Median	
0-5	07 (09.3)	00 (00.0)	07 (05.7)	01.7	02	00 (00.0)
6-17	11 (14.7)	06 (12.8)	17 (14.0)	12.9	13	06 (35.3)
18-25	07 (09.3)	17 (36.1)	24 (19.7)	22.3	22	17 (70.8)
26-45	23 (30.7)	14 (29.8)	37 (30.3)	34.5	35	14 (37.8)
46-55	13 (17.3)	06 (12.8)	19 (15.6)	51.9	53	06 (31.6)
Above 55	14 (18.7)	04 (08.5)	18 (14.7)	66.1	64	04 (22.2)
<b>All Ages</b>	<b>75 (100)</b>	<b>47 (100)</b>	<b>122 (100)</b>	<b>34.6</b>	<b>30</b>	<b>47 (38.5)</b>

**TABLE 5: EDUCATIONAL PROFILE**

Completed Education	Number of patients & per cent			Age Groups			
	No. completing education	Females completing education	Total Number	6-25	26-55	56 and above	All Patients
Illiterate	21 (20.2)	12 (27.9)	21 (18.3)	05 (23.8)	09 (42.9)	07 (33.3)	21 (100)
1-4 Std.	19 (18.3)	06 (14.0)	21 (18.3)	08 (38.1)	10 (47.6)	03 (14.3)	21 (100)
5-9 Std.	35 (33.7)	18 (41.9)	41 (35.7)	19 (46.3)	19 (46.3)	03 (07.4)	41 (100)
10 Std.	19 (18.3)	05 (11.6)	19 (16.5)	03 (15.8)	12 (63.2)	04 (21.0)	19 (100)
11-12 Std.	07 (06.7)	02 (04.6)	09 (07.8)	05 (62.5)	03 (37.5)	00 (00.0)	08 (100)
Graduation & above	04 (03.8)	-	04 (03.4)	00 (00.0)	03 (75.0)	01 (25.0)	04 (100)
<b>Total (n)</b>	<b>104 (100)</b>	<b>43 (100)</b>	<b>115 (100)</b>	<b>40 (35.1)</b>	<b>56 (49.1)</b>	<b>18 (15.8)</b>	<b>114 (100)</b>

**TABLE 6: MONTHLY INCOMES EARNED BY PATIENTS**

Patient's Cash Income (Rs per month)	Number & per cent			Average Income		No. & % Female
	Males	Females	All	Mean	Median	
00	27 (35.5)	41 (89.1)	68 (55.8)	0000.00	0000	41 (60.3)
1-1000	17 (22.4)	02 (04.3)	19 (15.6)	0784.21	1000	02 (10.5)
1001-2000	11 (14.5)	01 (02.2)	12 (09.8)	1750.00	2000	01 (08.3)

<b>20001-5000</b>	20 (26.3)	02 (04.3)	22 (18.0)	3322.18	3000	02 (09.1)
<b>5001 &amp; Above</b>	01 (01.3)	-	01 (00.8)	9000.00	9000	00 (00.0)
<b>Total (n)</b>	76 (100)	46 (100)	122 (100)	0967.12	0000	46 (38.2)

**TABLE 7: OCCUPATIONAL AND INCOME PROFILE OF PATIENTS (1)**

Occupation Profile	Number of patients & %		Patient's Income (Rupees per month)					Average Income	
	All	% Female	00	upto 1000	1001 - 2000	2001 - 5000	5000 +	ALL	Mean
Unemp/student/retired	27 (23.7)	22.2	23 (85.2)	00 (00.0)	03 (11.1)	01 (03.7)	00 (00.0)	27 (100)	310
Housework	35 (30.7)	100.0	35 (100)	00 (00.0)	00 (00.0)	00 (00.0)	00 (00.0)	35 (100)	000
Cultivation/agri. labour	08 (07.0)	12.5	01 (12.5)	05 (62.5)	00 (00.0)	01 (12.5)	00 (00.0)	07 (100)	843
Non-agri. manual labour	15 (13.2)	20.0	00 (00.0)	06 (40.0)	05 (33.3)	04 (26.7)	00 (00.0)	15 (100)	1667
Artisan/petty trader	12 (10.5)	08.3	00 (00.0)	06 (50.0)	03 (25.0)	02 (16.7)	01 (08.3)	12 (100)	2008
Indus./white collar wker	17 (14.9)	05.9	00 (00.0)	02 (11.8)	01 (05.8)	14 (82.4)	00 (00.0)	17 (100)	3212
<b>Total</b>	<b>114 (100)</b>	<b>41.2</b>	<b>59 (52.2)</b>	<b>19 (16.8)</b>	<b>12 (10.6)</b>	<b>22 (19.5)</b>	<b>01 (00.9)</b>	<b>113 (100)</b>	<b>967</b>

**TABLE 8: OCCUPATIONAL AND INCOME PROFILE OF PATIENTS (2)**

Occupational Categories	Number and per cent		Average Income (Rs)		Income as % of total household income			Per cent Earners in household		
	Male	Female	Male	Female	Male	Female	Total	Male	Female	Total
Unemployed/Student/Retired	21 (31.3)	06 (13.0)	399	000	20.0	00.0	15.4	26.1	30.4	27.0
Housework	-	35 (76.1)	-	000	-	00.0	00.0	-	32.6	32.6
Cultivation/Agricultural Labour	07 (10.4)	01 (02.1)	843	NR	94.4	NR	94.4	44.5	66.7	47.3
Non-agricultural manual labour	12 (17.9)	03 (06.5)	1667	1667	77.5	66.4	75.1	46.1	49.8	46.9
Artisan/petty trader	11 (16.4)	01 (02.1)	2136	600	84.2	30.0	79.6	39.8	50.0	40.6
Industrial/white collar worker	16 (23.9)	01 (02.1)	3195	3500	92.5	31.8	88.9	31.3	66.7	33.4
<b>Total</b>	<b>67 (100)</b>	<b>46 (100)</b>	<b>1433</b>	<b>198</b>	<b>57.9</b>	<b>05.7</b>	<b>37.7</b>	<b>35.0</b>	<b>35.4</b>	<b>35.1</b>

**TABLE 9 : HOUSEHOLD SIZE, SEX AND DEPENDENCY RATIOS**

Household Size (No.Of Persons)		Sex Ratio: No.of females per 1000 males		Dependence Ratios No.of non-earners per earner			
No. & %		No. & %		Nature of eco. relations	No. & %	Mean	Median

<b>1-4</b>	54 (44.6)	<b>000-500</b>	49 (40.8)	<b>No non-earners</b>	04 (03.3)	0.0	0.0
<b>5-7</b>	57 (47.1)	<b>501-1000</b>	39 (32.5)	<b>More earners</b>	17 (13.8)	0.5	0.5
<b>8 &amp; above</b>	10 (08.3)	<b>1001-1500</b>	15 (12.5)	<b>Nonearners=Earners</b>	13 (10.6)	1.0	1.0
<b>TOTAL</b>	121 (100)	<b>1501 &amp; above</b>	17 (14.2)	<b>More non-earners</b>	79 (64.2)	3.3	3.0
<i>Mean</i>	4.9	<b>Total</b>	120 (100)	<b>No response</b>	10 (08.1)	-	-
<i>Median</i>	5.0	<i>Mean</i>	989	<b>Total</b>	123 (100)	2.5	2.0
		<i>Median</i>	750				

**TABLE 10: MONTHLY HOUSEHOLD AND PER CAPITA INCOMES**

<b>Total Household Cash Income (Rs/Month)</b>				<b>Per Capita Household Cash Income (Rs/Month)</b>			
	<b>No. &amp; %</b>	<b>Mean</b>	<b>Median</b>		<b>No. &amp; %</b>	<b>Mean</b>	<b>Median</b>
<b>Upto 1000</b>	29 (25.2)	0703.5	0800.0	<b>Upto 250</b>	26 (22.6)	162.3	155.0
<b>1001-2000</b>	30 (26.1)	1751.7	1750.0	<b>251-500</b>	40 (34.8)	386.3	375.0
<b>2001-5000</b>	45 (39.1)	3378.6	3000.0	<b>501-1000</b>	33 (28.7)	732.2	685.7
<b>5001 &amp; above</b>	11 (09.6)	8290.9	7000.0	<b>1001 &amp; above</b>	16 (13.9)	1756.8	1379.2
<b>TOTAL</b>	<b>115 (100)</b>	<b>2749.5</b>	<b>2000.0</b>	<b>TOTAL</b>	<b>115 (100)</b>	<b>625.6</b>	<b>428.6</b>

**TABLE 11: RELIGION AND CASTE PROFILE OF PATIENTS**

<b>Castes</b>	<b>Religion</b>						<b>Total</b>
	<b>Hindu</b>	<b>Buddhist</b>	<b>Muslim</b>	<b>Christia n</b>	<b>Sikh</b>	<b>Jain</b>	
Upper castes	35	-	-	-	-	-	35 (28.5)
Middle castes	32	-	-	-	-	-	32 (26.0)
Scheduled castes	12	08	-	-	-	-	20 (16.3)
No response	13	-	13	04	04	02	36 (29.3)
<b>TOTAL</b>	<b>92 (74.8)</b>	<b>08 (06.5)</b>	<b>13 (10.6)</b>	<b>04 (03.3)</b>	<b>04 (03.3)</b>	<b>02 (01.6)</b>	<b>123 (100)</b>

**TABLE 12: MARITAL STATUS OF PATIENTS**

<b>Marital status</b>	<b>Number and per cent</b>	<b>Age Groups ( in completed years)</b>		
		<b>0-17</b>	<b>18-45</b>	<b>46 &amp; Above</b>
<b>Never married</b>	34 (27.9)	24 (70.6)	07 (20.6)	03 (08.8)
<b>Currently married</b>	81 (66.4)	00	52 (64.2)	29 (35.8)
<b>Separate/widowed</b>	07 (05.7)	00	02 (28.6)	05 (71.4)
<b>TOTAL (N)</b>	122 (100)	24 (19.7)	61 (50.0)	37 (30.3)

**TABLE 13: PATIENTS' RESIDENCE**

<b>Patient's Residence</b>	<b>No. &amp; %</b>
<b>Mumbai</b>	87 (70.7)
<b>Urban Maharashtra</b>	14 (11.4)
<b>Rural Maharashtra</b>	13 (10.5)
<b>Outside Maharashtra</b>	09 (07.4)
<b>Total</b>	<b>123 (100)</b>

**TABLE 14: LIVING CONDITIONS**

	Location of patient's house			
	Slum/Chawl/ Pavement	Flat	Other	Total
<b>Total Number &amp; Percent</b>	85 (71.4)	18 (15.1)	16 (13.5)	119 (100)
<b>Patient's Residence</b>				
In Mumbai	70 (82.4)	14 (77.8)	02 (12.5)	86 (72.3)
Outside Mumbai	15 (17.6)	04 (22.2)	14 (87.5)	33 (27.7)
<b>TOTAL</b>	<b>85 (100)</b>	<b>18 (100)</b>	<b>16 (100)</b>	<b>119 (100)</b>
<b>Area of the residence per capita (in sqft)</b>				
Upto 50 sq. ft.	56 (74.7)	04 (23.5)	08 (53.3)	68 (64.2)
> 50 - 100 sq. ft.	14 (18.7)	08 (47.1)	04 (26.7)	26 (24.5)
> 100 sq. ft.	04 (05.3)	05 (29.4)	03 (20.0)	12 (11.3)
<b>TOTAL</b>	<b>75 (100)</b>	<b>17 (100)</b>	<b>15 (100)</b>	<b>106 (100)</b>
Average area per capita (in sq. ft.)- <i>Mean</i>	47.8	84.5	71.1	57.1
Average area per capita (in sq. ft.)- <i>Median</i>	30.0	65.0	50.0	40.6
<b>House Ownership</b>				
Family owned	25 (37.3)	07 (41.2)	14 (87.5)	46 (46.0)
Rented	42 (62.7)	10 (58.8)	00 (00.0)	52 (52.0)
Other	00 (00.0)	00 (00.0)	02 (12.5)	02 (02.0)
<b>TOTAL</b>	<b>67 (100)</b>	<b>17 (100)</b>	<b>16 (100)</b>	<b>100 (100)</b>
<b>Monthly Household Income (in Rs.)</b>				
0 - 1000	17 (21.8)	01 (06.7)	10 (66.7)	28 (25.2)
1001 - 2000	23 (29.5)	04 (26.7)	01 (06.6)	28 (25.2)
2001 - 5000	32 (41.0)	08 (53.3)	04 (26.7)	44 (39.7)
5001 and above	06 (07.7)	05 (33.3)	00 (00.0)	11 (09.9)
<b>TOTAL</b>	<b>78 (100)</b>	<b>18 (100)</b>	<b>15 (100)</b>	<b>111 (100)</b>

**TABLE 15: DURATION OF ILLNESS BEFORE ADMISSION & MEDICAL HELP SOUGHT**

Duration of Illness	Number & %	Number of Providers approached				
		None	One	Two	3 & more	All
<b>0-7</b>	11 (08.9)	08 (72.7)	03 (27.3)	-	-	11 (100)
<b>8-14</b>	04 (03.2)	02 (50.0)	02 (50.0)	-	-	04 (100)
<b>15-21</b>	12 (09.7)	03 (25.0)	08 (66.7)	-	01 (08.3)	12 (100)
<b>22 &amp; Above</b>	75 (61.0)	16 (21.6)	41 (55.4)	10 (13.5)	07 (09.5)	74 (100)
<b>Not applicable</b>	16 (13.0)	09 (56.3)	06 (37.5)	-	01 (06.3)	16 (100)
<b>No response</b>	05 (04.1)	01 (20.0)	02 (40.0)	02 (40.0)	-	05 (100)
<b>Total</b>	122 (100)	39 (32.0)	62 (50.8)	12 (09.8)	09 (07.4)	122 (100)

**TABLE 16: PROVIDERS APPROACHED BEFORE HOSPITALISATION**

TOTAL NUMBER of providers approached		FIRST provider approached		TYPES of providers approached (exc. LTMGH)
	No. & %		No. & %	Number & %

<b>None</b>	39 (32.0)	<b>LTMGH</b>	39 (32.0)	-
<b>One</b>	62 (50.8)	<b>Private/NGO Provider</b>	61 (50.0)	85 (73.9)
<b>Two</b>	12 (09.8)	<b>Govt./Municipal Provider</b>	20 (16.4)	28 (24.4)
<b>More than two</b>	09 (07.4)	<b>Any Other</b>	02 (01.6)	02 (01.7)
<b>Total</b>	122 (100)	<b>Total</b>	122 (100)	115 (100)

**TABLE 17: DISCONTINUATION OF PROVIDERS - REASONS**

Reasons for discontinuance	Types of Providers			
	Private/NGO	Govt/Municipal	Others	All Providers
Ineffective treatment/disillusionment	39 (55.7)	06 (24.0)	01 (50.0)	46 (47.4)
Lack of required facilities	02 (02.9)	07 (28.0)	-	09 (09.3)
Referred to LTMG/elsewhere	24 (34.3)	07 (28.0)	01 (50.0)	32 (33.0)
Any other	05 (07.1)	05 (20.0)	-	10 (10.3)
<b>Total</b>	<b>70 (100)</b>	<b>25 (100)</b>	<b>02 (100)</b>	<b>97 (100)</b>
	<b>70 (72.2)</b>	<b>25 (25.7)</b>	<b>02 (2.1)</b>	<b>97 (100)</b>

**TABLE 18: DISCONTINUATION OF PROVIDERS -REASONS BY DURATION OF TREATMENT**

Reasons for Discontinuation & Duration of treatment	Providers			
	Private	Govt/Municipal	Any other	Total
<b>Ineffective treatment/ disillusionment</b>				
0-7 days	11 (28.2)	01 (16.7)	00 (00.0)	12 (16.1)
8-14 days	08 (20.5)	00 (00.0)	00 (00.0)	08 (17.4)
15 days & more	20 (51.3)	05 (83.3)	01 (100)	26 (56.5)
<b>Total</b>	<b>39 (100)</b>	<b>06 (100)</b>	<b>01 (100)</b>	<b>46 (100)</b>
<b>Lack of required facilities</b>				
0-7 days	01 (50.0)	05 (71.4)	00 (00.0)	06 (66.7)
8-14 days	01 (50.0)	00 (00.0)	00 (00.0)	01 (11.1)
15 days & more	00 (00.0)	02 (28.6)	00 (00.0)	02 (22.2)
<b>Total</b>	<b>02 (100)</b>	<b>07 (100)</b>	<b>00 (00.0)</b>	<b>09 (100)</b>
<b>Referred to LTMGH/Elsewhere</b>				
0-7 days	14 (58.3)	03 (42.9)	01 (100)	18 (56.3)
8-14 days	03 (12.5)	00 (00.0)	00 (00.0)	03 (09.3)
15 days & more	07 (29.2)	04 (57.1)	00 (00.0)	11 ((34.4)
<b>Total</b>	<b>24 (100)</b>	<b>07 (100)</b>	<b>01 (100)</b>	<b>32 (100)</b>
<b>Any other</b>				
0-7 days	01 (20.0)	01 (20.0)	00 (00.0)	02 (20.0)
8-14 days	01 (20.0)	00 (00.0)	00 (00.0)	01 (10.0)
15 days & more	03 (60.0)	04 (80.0)	00 (00.0)	07 (70.0)
<b>Total</b>	<b>05 (100)</b>	<b>05 (100)</b>	<b>00 (00.0)</b>	<b>10 (100)</b>

**TABLE 19: COST OF TREATMENT BEFORE HOSPITALISATION**

Cost (in Rs)	No. & %	Types of provider (percentage share)			Average Cost	
		Private/NGO	Govt/Municipal	Others	Mean	Median
00	07 (08.7)	25.0	75.0	00.0	00000.0	0000
01-1000	38 (48.1)	68.2	27.3	04.5	00399.2	0400
1001-2000	10 (12.7)	80.0	20.0	00.0	01620.0	1500
2001-5000	12 (15.2)	95.0	05.0	00.0	03470.0	3455
5001 +	12 (15.2)	78.3	21.7	00.0	10591.7	9900
<b>Total</b>	<b>79 (100)</b>	<b>73.9</b>	<b>24.4</b>	<b>01.7</b>	<b>02533.0</b>	<b>0700</b>

**TABLE 20: FAMILIARITY WITH LTMGH**

	Previous Contact with LTMGH		All patients
	None	At least one	
<b>Acquaintance with Staff</b>			
Acquainted with staff and helped	13 (15.5)	07 (19.4)	20 (16.3)
Acquainted with staff but not helped	03 (03.5)	01 (02.8)	04 (03.3)
No acquaintance with staff	66 (78.6)	27 (75.0)	96 (78.0)
No response	02 (02.4)	01 (02.8)	03 (02.4)
<b>TOTALS</b>	<b>84 (100)</b>	<b>36 (100)</b>	<b>123 (100)</b>
<b>Seeking Treatment in other BMC Hospitals</b>			
Yes	14 (16.7)	10 (27.8)	25 (20.3)
No	66 (78.6)	24 (66.7)	92 (74.8)
No response	04 (04.8)	02 (05.6)	06 (04.9)
<b>TOTALS</b>	<b>84 (100)</b>	<b>36 (100)</b>	<b>123 (100)</b>

**TABLE 21: REASONS FOR COMING TO THE LTMGH**

Reasons for approaching LTMGH	Number of patients & per cent		
	Lives in Mumbai	Lives elsewhere	All patients
Can't say	03 (03.5)	-	03 (02.5)
Friends relatives suggested/ knew staff/works in hospital	23 (26.7)	13 (36.1)	36 (29.5)
Referred by other providers/their treatment not effective	29 (33.7)	20 (55.6)	49 (40.2)
Good hospital/good previous experience	49 (57.0)	14 (38.9)	63 (51.6)
Hospital is free/cannot afford	16 (18.6)	06 (16.7)	22 (18.0)
Hospital is nearby	24 (27.9)	04 (11.1)	28 (23.0)
No choice (accident/brought by police) and any other	09 (10.5)	02 (05.6)	11 (09.0)
<b>Total: (N = 122)</b>	<b>86</b>	<b>36</b>	<b>122</b>
	<b>No prior contact</b>	<b>Prior contact</b>	<b>All patients</b>
Can't say	03 (03.6)	-	03 (02.5)
Friends relatives suggested/ knew staff/works in hospital	22 (26.2)	14 (38.9)	36 (29.5)
Referred by other providers/ their treatment not effective	42 (50.0)	07 (19.4)	49 (40.2)

Good hospital/good previous experience	33 (39.3)	28 (77.8)	63 (51.6)
Hospital is free/cannot afford	17 (20.2)	05 (13.9)	22 (18.0)
Hospital is nearby	15 (17.9)	11 (30.6)	28 (23.0)
No choice (accident/brought by police) and any other	09 (10.7)	02 (05.6)	11 (09.0)
<b>Total: (N = 122)</b>	<b>84</b>	<b>36</b>	<b>122</b>

**TABLE 22: PROBLEMS WITH PROCEDURES PRIOR TO ADMISSION**

	Yes	No	NA	NR	Totals
<b>Problems seeking admission</b>	12 (10.0)	106 (88.3)	02 (01.7)	-	120 (100)
<b>Problems while form filling</b>	10 (08.3)	106 (88.3)	02 (01.7)	02 (01.7)	120 (100)
<b>Delays in getting a bed</b>	25 (20.8)	90 (75.0)	02 (01.7)	03 (02.5)	120 (100)
<b>Getting info. about procedures</b>	90 (75.0)	23 (19.2)	02 (01.7)	05 (04.2)	120 (100)

**TABLE 23: PHYSICAL FACILITIES IN THE WARDS**

Physical Facilities	Average Number ( <i>Mean</i> )					Per cent of wards with shortages of physical facilities
	Supplied per patient	Supplied per bed	Available per patient	Available per bed	In use per patient	
<b>Mattresses</b>	1.29	1.09	1.30	1.08	1.28	42.86
<b>Bedsheets</b>	7.26	6.43	2.81	3.30	2.05	0.00
<b>Blankets</b>	1.05	0.74	1.07	0.73	0.94	71.43
<b>Pillow covers</b>	1.96	1.44	1.89	1.25	1.25	38.46
<b>Bed pans</b>	0.28	0.25	0.27	0.17	0.22	93.75
<b>Urine pots</b>	0.38	0.34	0.34	0.29	0.24	100.00
<b>Spitoons</b>	0.45	0.38	0.42	0.38	0.34	93.75
<b>Lockers</b>	1.15	0.96	1.11	0.95	1.11	50.00
<b>Stools</b>	0.82	0.63	0.80	0.63	0.80	87.50
<b>Stretchers</b>	0.10	0.08	0.09	0.07	0.09	-
<b>Wheel chairs</b>	0.13	0.09	0.11	0.07	0.11	-
<b>Oxygen cylinders</b>	0.14	0.11	0.13	0.11	0.13	-
<b>Towels</b>	2.65	2.37	0.74	0.74	0.55	80.00

Source : Questionnaire filled up by Sisters-in-charge of the wards

**TABLE 24: PROVISION OF SELECTED FACILITIES**

	Bed	Linen	Clothes
<b>Provision</b>			
Provided immediately after admission	82 (66.7)	68 (55.3)	88 (71.5)
Provided some days after admission	07 (05.7)	05 (04.1)	09 (07.3)
Provided but no information on time/delay	29 (23.6)	14 (11.4)	05 (04.1)
Not provided	04 (03.2)	24 (19.5)	20 (16.3)
No response	01 (00.8)	12 (09.8)	01 (00.8)
<b>TOTALS</b>	<b>123 (100)</b>	<b>123 (100)</b>	<b>123 (100)</b>
<b>Duration for which facility not provided</b>			
Facility provided immediately	82 (66.7)	68 (55.3)	88 (71.5)
Upto 10 per cent of stay in the hospital	02 (01.6)	-	03 (02.4)
Ten to 20 per cent of stay in the hospital	01 (00.8)	01 (00.8)	02 (01.6)

More than 20 per cent of stay in the hospital	04 (03.2)	04 (03.2)	04 (03.2)
Not applicable/Facility not provided	04 (03.2)	24 (19.5)	20 (16.3)
No response	30 (24.4)	26 (21.1)	06 (04.9)
<b>TOTALS</b>	<b>123 (100)</b>	<b>123 (100)</b>	<b>123 (100)</b>
<b>Average intervals at which facility changed</b>			
Changed daily	-	17 (13.8)	06 (04.9)
Changed on alternate days	-	07 (05.7)	07 (05.7)
Changed once in three days	-	18 (14.6)	18 (14.6)
Changed once in four to seven days	-	18 (14.6)	11 (08.9)
Changed once in over seven days	-	09 (07.3)	09 (07.3)
Never changed	-	26 (21.1)	34 (27.6)
Not applicable/ Facility not provided	-	24 (19.5)	20 (16.3)
No response	-	04 (03.2)	18 (14.6)
<b>TOTALS</b>	<b>-</b>	<b>123 (100)</b>	<b>123 (100)</b>
<b>Provision and condition of facility</b>			
Provided and good quality	-	-	10 (13.0)
Provided but poor quality	-	-	73 (59.3)
Provided but no information on quality	-	-	16 (13.0)
Not provided	-	-	20 (16.3)
No response	-	-	04 (03.2)
<b>TOTALS</b>	<b>-</b>	<b>-</b>	<b>123 (100)</b>

Notes : Mattresses on the floor are treated as beds not provided

Two out of three items of linen not given to patients are treated as linen not provided

**TABLE 25: PERSONNEL IN THE WARDS**

	Sanctioned Staff		Appointed Staff		Available Staff	
	Ratio of Patients:Staff	Ratio of Beds:Staff	Ratio of Patients:Staff	Ratio of Beds:Staff	Ratio of Patients:Staff	Ratio of Beds:Staff
<b>Ayahs</b>	10.17	08.50	11.10	09.60	11.65	09.92
<b>Wardboys</b>	09.48	10.02	11.03	11.26	11.34	11.48
<b>Nurses</b>	04.28	04.33	05.02	04.30	05.02	04.30
<b>Sweepers</b>	05.70	05.66	07.66	07.45	08.46	08.29

Source : Questionnaire filled up by Sisters-in-charge of the wards

**TABLE 26: DISSEMINATION AND INFORMATION ON ILLNESS AND CURE**

Information Given By Doctors	Number
Information given (readily or when asked) and understood by patient	82 (66.7)
Information given (readily or when asked) but not fully understood by patient	16 (13.0)
Information not given	21 (17.1)
No response	04 (03.3)
<b>TOTAL</b>	<b>123 (100)</b>

**TABLE 27: PERCEIVED COMPETENCE OF MEDICAL AND PARA-MEDICAL STAFF**

	Doctors	Nurses
--	---------	--------



All are competent	109 (88.6)	113 (91.9)
Some are competent	03 (02.4)	05 (04.1)
Cannot say/ No response	11 (09.0)	05 (04.1)
<b>TOTALS</b>	<b>123 (100)</b>	<b>123 (100)</b>

**TABLE 28: REPORTED BEHAVIOUR OF MEDICAL AND NON-MEDICAL STAFF**

<b>Kind of Behaviour</b>	<b>Doctors</b>	<b>Nurses</b>	<b>Ayahs</b>	<b>Wardboys</b>
Positive: good, polite, helpful, kind, patient	111 (90.4)	116 (94.3)	60 (48.8)	62 (50.4)
Tolerable	04 (03.3)	04 (03.3)	09 (07.3)	09 (07.3)
Negative	03 (02.4)	02 (01.6)	06 (04.9)	02 (01.6)
Any other	04 (03.3)	-	02 (01.6)	01 (00.8)
No response	01 (00.8)	01 (00.8)	46 (37.4)	49 (39.8)
<b>TOTALS</b>	<b>123 (100)</b>	<b>123 (100)</b>	<b>123 (100)</b>	<b>123 (100)</b>

**TABLE 29: PROVISION OF MEDICAL FACILITIES**

<b>Provision by Hospital</b>	<b>Medicines</b>			<b>Diagnostic Tests</b>		
	<b>Number</b>	<b>Average Expenditure</b>		<b>Number</b>	<b>Average Expenditure</b>	
		<i>Mean</i>	<i>Median</i>		<i>Mean</i>	<i>Median</i>
Complete provision	24 (19.5)	0327.38	000.00	79 (64.2)	0330.49	000.00
Less than complete	71 (57.7)	1052.22	300.00	18 (14.6)	3217.06	500.00
No provision	14 (11.4)	0584.62	500.00	01 (00.8)	0400.00	-
Not required	-	-	-	23 (18.7)	-	-
No response	14 (11.4)	0542.08	012.50	02 (01.6)	0100.00	-
<b>TOTAL</b>	<b>123 (100)</b>	<b>0802.93</b>	<b>200.00</b>	<b>123 (100)</b>	<b>0721.61</b>	<b>000.00</b>

**TABLE 30: DEPARTMENT WISE BREAKUP OF EXPENDITURE ON MEDICINES AND DIAGNOSTIC TESTS**

<b>Department</b>	<b>Total</b>	<b>Expenditure on medicines</b>			<b>Expenditure on Tests</b>		
		<b>Range</b>	<b>Mean</b>	<b>Median</b>	<b>Range</b>	<b>Mean</b>	<b>Median</b>
<b>Gynaecology</b>	27	0-3500	520.94	200.00	0-60	3.33	0.00
<b>Medicine</b>	26	0-1000	200.60	50.00	0-15000	901.82	0.00
<b>Surgery</b>	20	0-2000	674.17	500.00	0-30000	1825.26	0.00
<b>Orthopaedics</b>	11	0-15000	2977.27	600.00	0-3775	476.82	30.00
<b>Ophthalmology</b>	08	0-1500	680.00	600.00	0-400	126.25	30.00
<b>Paed. Surgery</b>	06	0-200	62.50	27.50	0-200	46.67	0.00
<b>Paediatrics</b>	05	0-300	151.40	200.00	0-870	184.00	0.00
<b>Neurosurgery</b>	04	10-2000	594.25	183.50	0-5500	1570.00	390.00
<b>CVTS</b>	03	100-2000	751.33	154.00	0-4000	1833.33	1500.00
<b>ENT</b>	03	0-103	54.33	60.00	0-500	186.67	60.00
<b>Cardiology</b>	02	150-500	325.00	325.00	0-1580	790.00	790.00
<b>Urology</b>	02	400-3000	1700.00	1700.00	0-1200	600.00	600.00
<b>AKD</b>	01	3500	-	-	0	-	-

Plastic Surgery	01	4000	-	-	0	-	-
Respiratory	01	80	-	-	1500	-	-
Skin	01	70	-	-	0	-	-
Gastroentriology	01	1500	-	-	0	-	-
No response	01	-	-	-	-	-	-
<b>All Departments</b>	<b>123</b>	<b>0-15000</b>	<b>802.93</b>	<b>200.00</b>	<b>0-30000</b>	<b>721.61</b>	<b>0</b>

**TABLE 31: TOTAL EXPENDITURE AT LTMGH**

Range of Expenditure	Number & per cent	Average Expenditure	
		Mean	Median
No Expenditure	14 (13.2)	00.0	00.0
1-500	42 (39.6)	182.5	181.5
501-1000	14 (13.2)	702.1	670.0
1001-2000	19 (17.9)	1430.2	1500.0
2001-5000	11 (10.4)	3298.6	3500.0
5001-10,000	03 (02.8)	6739.0	6000.0
10,001-32,000	03 (02.8)	21233.3	16000.0
<b>TOTALS</b>	<b>106 (100)</b>	<b>1555.4</b>	<b>400.0</b>

**TABLE 32: PER DAY COST AT LTMGH**

Range of Expendtr (Rs.)	Number	Average Expenditure		Average Income		Expenditure over hh. income		
		Mean	Median	Mean	Median	Patients with per day expd. > per day Income	Exp. as % of Income Mean	Exp. as % of Income Median
0	14 (13.5)	00.0	00.0	74.0	58.3	00.0 %	00.0	00.0
1-50	42 (40.4)	25.2	23.4	82.9	58.3	15.8 %	65.6	36.9
51-100	12 (11.5)	79.5	82.5	143.9	116.7	18.2 %	70.5	66.7
101-200	07 (6.7)	171.1	166.7	102.4	100.0	71.4 %	244.4	180.0
201-500	17 (16.3)	319.3	280.0	85.2	75.0	100.0 %	632.3	385.2
501-2600	12 (11.5)	1145.0	944.4	115.2	83.3	100.0 %	1430.1	1196.7
<b>TOTALS</b>	<b>104 (100)</b>	<b>215.2</b>	<b>50.0</b>	<b>91.7</b>	<b>66.7</b>	<b>41.8 %</b>	<b>329.2</b>	<b>80.6</b>

**TABLE 33: BREAK UP OF EXPENDITURE AT LTMGH**

Range of Expdtr (Rs.)	Expenditure on medicines				Expenditure on diagnostic tests				Expenditure on bed rent		
	No.	Average Mean	Average Median	% of total exp.	No.	Average Mean	Average Median	% of total exp.	No.	Average Mean	Average Median
0	22 (17.9)	0.0	0.0	00.0	63 (51.2)	00.0	00.0	0.00	105 (85.4)	00.0	00.0
1-100	20 (16.3)	43.5	50.0	66.3	19 (15.4)	43.2	40.0	28.47	01 (00.8)	20.0	66.3
101-200	15 (12.2)	169.5	200.0	79.6	01 (00.8)	200.0	-	50.00	01 (00.8)	200.0	-

<b>201-500</b>	22 (17.9)	386.6	375.0	69.5	09 (07.3)	393.3	400.0	60.94	04 (03.3)	395.0	365.0	4
<b>501-1000</b>	11 (08.9)	900.0	1000.0	81.2	03 (02.4)	760.0	750.0	74.20	02 (01.6)	630.0	630.0	0
<b>1001-1500</b>	06 (04.9)	1417.3	1500.0	96.9	07 (05.7)	1280.0	1200.0	74.70	-	-	-	-
<b>1501 +</b>	14 (11.4)	3555.6	2500.0	88.4	07 (05.7)	8979.3	4000.0	85.70	-	-	-	-
<b>No response</b>	13 (10.6)	-	-	-	14 (11.4)	-	-	-	10 (08.1)	-	-	-
<b>TOTALS</b>	<b>123 (100)</b>	<b>802.9</b>	<b>200.0</b>	<b>69.7</b>	<b>123 (100)</b>	<b>721.6</b>	<b>00.0</b>	<b>26.13</b>	<b>123 (100)</b>	<b>27.1</b>	<b>00.0</b>	<b>0</b>

**TABLE 34: LEVELS OF SATISFACTION WITH COMPONENTS OF CARE PROVIDED BY LTMGH**

	Level Of Satisfaction				No Response (No. & as % over 123)
	Average score on 0-3 scale	Below average	Above average	Total	
<b>Admission procedures</b>	2.79	23 (19.1)	98 (80.9)	121 (100.0)	02 (01.6)
<b>Hospital ward</b>	2.82	21 (17.6)	98 (82.4)	119 (100.0)	04 (03.3)
<b>Toilet in the ward</b>	2.71	27 (23.1)	90 (76.9)	117 (100.0)	06 (04.9)
<b>Facility for sleeping</b>	2.78	24 (19.8)	97 (80.2)	121 (100.0)	02 (01.6)
<b>Linen</b>	2.47	42 (35.3)	77 (64.7)	119 (100.0)	04 (03.3)
<b>Clothes</b>	2.22	58 (51.8)	54 (48.2)	112 (100.0)	11 (08.9)
<b>Food</b>	2.40	47 (46.1)	55 (53.9)	102 (100.0)	21 (17.1)
<b>Doctors</b>	2.93	07 (05.9)	112 (94.1)	119 (100.0)	04 (03.3)
<b>Nurses</b>	2.92	09 (07.6)	110 (92.4)	119 (100.0)	04 (03.3)
<b>Wardboys</b>	2.76	22 (22.0)	78 (78.0)	100 (100.0)	23 (18.7)
<b>Ayahs</b>	2.72	26 (22.6)	89 (77.4)	115 (100.0)	08 (06.5)
<b>Overall satisfaction</b>	2.65	29 (39.7)	44 (60.3)	73 (100.0)	50 (40.7)

**TABLE 35: REASONS FOR SATISFACTION AND DISSATISFACTION**

	Level Of Satisfaction		All respondents
	Below average	Above average	
<b>REASONS FOR SATISFACTION</b>			
Cannot say	-	01 (02.3)	01 (00.8)
Facilities are good/satisfactory	02 (06.9)	15 (34.1)	35 (28.5)
Service provided by the staff is good/timely	17 (58.6)	09 (20.5)	41 (33.3)
Good recovery/good treatment/feeling better	05 (17.2)	06 (13.3)	23 (18.7)
Hospital is free/grateful for free treatment	04 (13.8)	05 (11.4)	16 (13.0)
Hospital is in the vicinity of the residence	04 (13.8)	03 (06.8)	09 (07.3)
There is no other alternative/all hospitals are the same	01 (03.4)	02 (04.5)	03 (02.4)
Hospital is in keeping with ones expectations	-	01 (02.3)	01 (00.8)
Cannot say/No Response	05 (17.2)	19 (43.2)	38 (30.9)
<b>TOTAL NUMBER OF RESPONDENTS</b>	<b>29</b>	<b>44</b>	<b>123</b>
<b>REASONS FOR DISSATISFACTION</b>			
Facilities are unsatisfactory	07 (24.1)	-	09 (07.3)

Doctors do not give sufficient information/hospital personnel are careless	03 (10.3)	02 (04.5)	06 (04.9)
There has been no relief from symptoms	01 (03.4)	-	03 (02.4)
Not in keeping with ones expectation	01 (03.4)	-	01 (00.8)
Any other	06 (20.7)	01 (02.3)	09 (07.3)
No Response	06 (20.7)	02 (04.5)	11 (08.9)
<b>TOTAL NUMBER OF RESPONDENTS</b>	<b>29</b>	<b>44</b>	<b>123</b>

Notes : Multiple responses. Percentages in parantheses are calculated over total number of cases and not over total number of responses

**TABLE 36: PATIENTS' RECOMMENDATIONS FOR IMPROVEMENT**

NATURE OF RECOMMENDATIONS	NUMBER
No improvements necessary/ There is nothing wrong with the hospital	08 (06.5)
Supply of medicines and equipment need to be improved	11 (08.9)
Better behaviour and sufficiency of staff would help	11 (08.9)
Better living conditions in the ward in terms of physical layout and facilities	57 (46.3)
Facilities for relatives accompanying patients at a moderate cost	03 (02.4)
Any other	09 (07.3)
Cannot say/ No comments	48 (39.0)
No improvements possible	02 (01.6)
No response	08 (06.5)
<b>TOTAL NUMBER OF PATIENTS</b>	<b>123</b>

Notes : Multiple responses  
Percentages in parantheses are calculated over total number of cases and not over total number of responses

**TABLE 37: SOCIO-ECONOMIC FACTORS AFFECTING OVERALL SATISFACTION**

	Totals	Level of satisfaction		Degree of Association	Level of Significance
		Below average	Above average		
<b>Sex</b>					
Male	51	21 (41.2)	30 (58.8)	$\phi = 0.04513$ <i>no association</i>	$p > 0.05$ <i>no significance</i>
Female	22	08 (36.4)	14 (63.6)		
<b>Education</b>				$\gamma = 0.3145$ <i>low association</i>	$p < 0.001$ <i>significance</i>
Illiterate/upto Std.4	30	15 (50.0)	15 (50.0)		
Std. 5-9	24	09 (37.5)	15 (62.5)		
Std.10 and more	15	04 (26.7)	11 (73.3)		
<b>Economic role in the household</b>				$\phi = -0.00619$ <i>no association</i>	$p > 0.05$ <i>no significance</i>
Non-earner	33	13 (39.4)	20 (60.6)		
Earners	35	14 (40.0)	21 (60.0)		
<b>Per day expenditure at LTMG</b>				$r_t = -0.01$ <i>no association</i>	$p > 0.05$ <i>no significance</i>
Greater than per day hh. income	27	11 (40.7)	16 (59.3)		
Less than per day hh. income	39	16 (41.0)	23 (59.0)		
<b>Duration of stay at the hospital</b>				$\gamma = -0.0873$	$p > 0.05$
Less than three days	15	06 (40.0)	09 (60.0)		
Three days to one week	23	07 (30.4)	16 (69.6)		

One to two weeks	13	07 (53.8)	06 (46.2)	<i>no association</i>	<i>no significance</i>
More than two weeks	22	09 (40.9)	13 (59.1)		
<b>Access to the hospital</b>					
Helped by member of staff	08	07 (87.5)	01 (12.5)	$\phi = 0.3505$	$p > 0.05$
Not helped by member of staff	63	21 (33.3)	42 (66.7)	<i>low association</i>	<i>no significance</i>
<b>Familiarity with the hospital</b>					
No familiarity: first visit	54	22 (40.7)	32 (59.3)	$\phi = 0.03496$	$p > 0.05$
Not first visit	19	07 (36.8)	12 (63.2)	<i>no association</i>	<i>no significance</i>

**TABLE 38: FACTORS INFLUENCING SATISFACTION WITH PHYSICAL FACILITIES**

Provision of Physical Facilities	Level of Satisfaction		Totals
	Below Average	Above Average	
<b>Facility for Sleeping: Bed</b>			
Provided immediately after admission	15 (18.7)	65 (81.7)	80 (100)
Provided some days after admission	02 (28.6)	05 (71.4)	07 (100)
Provided but no information on time/delay	05 (17.2)	24 (82.8)	29 (100)
Not provided	02 (50.0)	02 (50.0)	04 (100)
No response	-	01 (100)	01 (100)
TOTAL	24 (80.2)	97 (80.2)	121 (100)
<b>Linen: Bedsheet, pillow case, blanket/cover</b>			
Provided immediately after admission	19 (25.3)	56 (74.7)	75 (100)
Provided some days after admission	03 (50.0)	03 (50.0)	06 (100)
Provided but no information on time/delay	09 (56.2)	07 (43.8)	16 (100)
Not provided	04 (80.0)	01 (20.0)	05 (100)
No response	07 (41.2)	10 (58.8)	17 (100)
TOTAL	42 (35.3)	77 (64.7)	119 (100)
<b>Hospital clothes: timeliness of provision</b>			
Provided immediately after admission	41 (50.0)	41 (50.0)	82 (100)
Provided some days after admission	04 (50.0)	04 (50.0)	08 (100)
Provided but no information on time/delay	04 (80.0)	01 (20.0)	05 (100)
Not provided	07 (58.3)	05 (41.7)	12 (100)
No response	02 (40.0)	03 (60.0)	05 (100)
TOTAL	58 (51.8)	54 (48.2)	112 (100)
<b>Hospital clothes: condition of garments</b>			
Provided and good quality	01 (10.0)	09 (90.0)	10 (100)
Provided but inferior quality	46 (63.9)	26 (36.1)	72 (100)
Provided but no information on quality	01 (20.0)	04 (80.0)	05 (100)
Not provided	07 (58.3)	05 (41.7)	12 (100)
No response	03 (23.1)	10 (76.9)	13 (100)
TOTAL	58 (51.8)	54 (48.2)	112 (100)

**TABLE 39: OVERALL SATISFACTION BY DEPARTMENT**

Level of Satisfaction
-----------------------

<b>Department</b>	<b>Below average</b>	<b>Above average</b>	<b>Totals</b>
<b>Obstetric &amp; gynaecology</b>	01 (14.3)	06 (85.7)	07 (100)
<b>Medicine</b>	09 (50.0)	09 (50.0)	18 (100)
<b>Surgery</b>	01 (07.7)	12 (92.3)	13 (100)
<b>Orthopaedics</b>	06 (85.7)	01 (14.3)	07 (100)
<b>Ophthalmology</b>	03 (50.0)	03 (50.0)	06 (100)
<b>Paediatric Surgery</b>	01 (50.0)	01 (50.0)	02 (100)
<b>Paediatrics</b>	02 (50.0)	02 (50.0)	04 (100)
<b>Neurosurgery</b>	02 (66.7)	01 (33.3)	03 (100)
<b>CVTS</b>	-	02 (100)	02 (100)
<b>ENT</b>	-	03 (100)	03 (100)
<b>Cardiology</b>	02 (100)	-	02 (100)
<b>Urology</b>	01 (50.0)	01 (50.0)	02 (100)
<b>AKD</b>	01 (100)	-	01 (100)
<b>Plastic Surgery</b>	-	01 (100)	01 (100)
<b>Respiratory</b>	-	01 (100)	01 (100)
<b>Skin</b>	NR	NR	NR
<b>Gastroentrolology</b>	NR	NR	NR

=====

*Annexure: 1*

**Study Of Patient Satisfaction In Lokmanya Tilak Municipal General**

**Hospital**

conducted by

**CEHAT**

Centre for Enquiry into Health and Allied Themes  
in collaboration with

**L.T.M.G. Hospital and Sion Senior Citizens Association**

## INTERVIEW SCHEDULE FOR IN-PATIENTS

*We are conducting a study on how satisfied patients are with the services offered by this hospital so that we can get some idea on how things can be improved. Since you are an in-patient at this hospital, we are interested in learning about your experiences here since your admission. Like you, we will be interviewing many other patients too. Please be sure that whatever information you give us will be kept strictly confidential and used for research purposes only. The information you give will not be used individually but as aggregate analysis. No names will be mentioned. However, if you have reservations about our study, you have a right to refuse to participate in it.*

Name of the patient: \_\_\_\_\_

Name of respondent (In case patient cannot answer): \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ years Relationship with patient: \_\_\_\_\_

Ward No.: \_\_\_\_\_ Department : \_\_\_\_\_ Unit: \_\_\_\_\_

Bed No.: \_\_\_\_\_ Date of Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_(d/m/y) Date of interview:  
\_\_\_\_/\_\_\_\_/\_\_\_\_(d/m/y)

Diagnosis (to be copied from case paper) \_\_\_\_\_

---

### PATIENT PROFILE

1. Patient's residence for most of the year : Bombay [ ] Outside Bombay [ ]
2. Complete address : \_\_\_\_\_  
\_\_\_\_\_
3. Sex : Male [ ] Female [ ] 4. Completed age : \_\_\_\_\_ years
5. Marital Status: Never married [ ] Currently married [ ] Separated/divorced [ ] Widowed [ ]
6. Religion: \_\_\_\_\_ 7. Caste: \_\_\_\_\_
8. Completed education: \_\_\_\_\_
9. Occupation: Employed [ ] Self Employed [ ] Student [ ] Housework [ ] Seeking employment [ ]  
Not working [ ] Any other: \_\_\_\_\_
- (a) If employed : Full time [ ] Part time [ ] Daily wages [ ]  
Confirmed [ ] Temporary/Probation [ ] Any other: \_\_\_\_\_



Name of the employer (institution): \_\_\_\_\_ Designation: \_\_\_\_\_

Nature of work: \_\_\_\_\_

\_\_\_\_\_ Monthly income (cash in hand): Rs. \_\_\_\_\_ per month

(b) If self employed : Nature of work: \_\_\_\_\_

Duration of work: Throughout the year [ ] For some months in the year [ ] Any other: \_\_\_\_\_

Average monthly income (cash in hand): Rs. \_\_\_\_\_ per month

(c) Other Occupation/Income related details: \_\_\_\_\_

10. Total family size : \_\_\_\_\_

<u>Relationship with patient</u>	<u>Sex</u>	<u>Age</u>	<u>Completed Edu</u>	<u>Occupation</u>	<u>Monthly Income</u>

11. Type of Housing : Slum [ ] On Pavement [ ] Chawl [ ] Flat [ ] Any other: \_\_\_\_\_

Ownership of house : Family owns house [ ] Rented house [ ] Any other (specify): \_\_\_\_\_

Approximate size of house: \_\_\_\_\_ ft. X \_\_\_\_\_ ft. **OR** \_\_\_\_\_ square ft.

Toilet : Inside the house [ ] Common toilet outside [ ] No toilet [ ] Any other: \_\_\_\_\_

12. Consumer Goods: Colour TV [ ] B/w TV [ ] Fridge [ ] Radio [ ] Tape Recorder [ ] Car [ ]

Motorcycle [ ] Scooter/Moped [ ] Any others: \_\_\_\_\_

#### **CONTACT WITH L.T.M.G. HOSPITAL**

13. Prior to this, have you ever come to Sion hospital ? Yes [ ] No [ ]

If yes, how many times have you come here ?

\_\_\_\_\_ times as an out-patient \_\_\_\_\_ times as an in-patient

\_\_\_\_\_ times while bringing other patient(s) here Any other: \_\_\_\_\_

14. What was your opinion about the hospital before coming here ? \_\_\_\_\_

---

15. How long have you been suffering from your present illness ? \_\_\_\_\_

16. For this current episode of illness, where did you go for treatment before coming to this hospital ?

<u>Medical Care Provider</u>	<u>For how long ?</u>	<u>Why did you discontinue?</u>	<u>Money spent</u>

17. Considering there are so many other hospitals you could have gone to, what made you come to this hospital for treatment ?

---

---

---

18. Were you referred to this hospital or did you come here on your own ?

Referred from OPD  Referred by govt. dispensary/hospital  Referred by private doctor/hospital

Came on my own to OPD  Came on my own for admission  Any other: \_\_\_\_\_

19. Are you acquainted with any of the staff of the hospital ? Yes  No

If yes, who ? Doctor  Nurse  Wardboy  Ayah  Clerk  Social worker

Any other: \_\_\_\_\_ No acquaintance

Did this person help you with your admission and stay at the hospital ?

Yes, this time  Not this time but in the past  Never  No Acquaintance

If no, were you helped by someone who knows a staff member or who knows procedures here ?

Yes, this time  Not this time but in the past  Never  Not Applicable

20. Have you been treated in any other Municipal/govt. hospitals in Bombay before? Yes [ ]  
No [ ]

**PATIENT'S PERCEPTION OF CARE RENDERED BY THE HOSPITAL**

21. Did you encounter any problems while seeking admission in the ward ? Yes [ ] No [ ]

Did you encounter delays in the process of registration/form filling ? Yes [ ] No [ ]

Did you encounter delays in the process of history taking ? Yes [ ] No [ ]

Was there a delay in getting a bed ? Yes [ ] No [ ]

Do you get information about the procedures to be followed easily ? Yes [ ] No [ ]

- 22.\* Provision of facilities for sleeping (*to be filled by interviewer without asking*) :

Bed [ ] Mattress on floor [ ] Any other: \_\_\_\_\_

How long after admission were you provided with a bed ? \_\_\_\_\_

- 23.\* Provision of linen - bedsheet, pillow cover, sheet for covering - (*to be filled by interviewer without asking*)

Bedsheet : Provided [ ] Not provided [ ]

Pillow cover : Provided [ ] Not provided [ ]

Sheet to cover oneself : Provided [ ] Not provided [ ]

How long after admission was bed linen provided ? (*Question to be asked if linen has been provided*)

Immediately after admitted [ ] After \_\_\_\_\_ hours After \_\_\_\_\_ days Not provided [ ]

After admission, have your sheets and covers been changed ? Yes [ ] No [ ]

If yes, how many times ? \_\_\_\_\_

- 24.\* Is the patient wearing a hospital gown (*to be filled by interviewer without asking*) : Yes [ ] No [ ]

Condition of the gown (*to be filled by interviewer without asking*) : Torn [ ] Does not fit [ ]

(*If patient is wearing a gown*) : Were you provided with a gown on admission ?

Immediately after admission [ ] After \_\_\_\_\_ hours After \_\_\_\_\_ days Not provided [ ]

How often has it been changed since then ?

- 
25. Are you disturbed by the noise in the ward ? Yes [ ] No [ ]

Do you think the ward is clean ? Yes [ ] No [ ]

- 26.** Have you been eating food provided by the hospital ? Yes  No
- What is your opinion about the quality of the food ? Good  Tolerably good  Bad
- Is the food sufficient ? Sufficient  Not always sufficient  Insufficient
- 27.** Has the hospital been providing you with clean drinking water ?
- Yes, provided without having to ask  Provided only when asked  Not provided at all
- 28.** Have you had any direct contact with any of the wardboys of the hospital so far? Yes
- No
- How would you describe their behaviour towards patients ? \_\_\_\_\_
- 29.** Have you had any direct contact with any of the ayahs of the hospital so far ? Yes  No
- ]
- How would you describe their behaviour towards patients ? \_\_\_\_\_
- 30.** How many of your medicines have been provided by the hospital ? \_\_\_\_\_ out of \_\_\_\_\_
- \_\_\_\_\_
- Have these been given on time ? On time  Erratically  Never on time
- 31.** Have you been required to do diagnostic tests so far ? Yes  No
- If yes, were all of these done in the hospital or were you required to do some outside the hospital ?
- Wholly done in hospital  Partly done in hospital  Not done in hospital
- 32.** Did the doctor(s) treating you explain about the nature of your illness and its cure ?
- Gave information readily  Gave information only when I asked  Did not give information
- I did not ask for information  Any other: \_\_\_\_\_
- If information was given, were you able to understand what the doctor said ?
- Able to understand everything clearly  Able to understand only some things
- Unable to understand anything  No information was given
- Would you say that that the doctor(s) attending to you are competent ?
- Yes, all of them  Some are competent  None are competent
- How would you describe the behaviour of doctors ?
- \_\_\_\_\_
- 33.** Would you say that that the nurses attending to you are competent ?

Yes, all of them  Some are competent  None are competent

How would you describe their behaviour towards patients ?

\_\_\_\_\_

34. Have any of your relatives/friends been staying with you at the hospital ? Yes  No

How would you describe facilities provided for them ?

*Facilities for Eating* : Adequate & good  Good but inadequate  No facilities

*Facilities for sleeping* :

Adequate & good  Good but inadequate  No facilities

35. So far, how much money have you spent during your stay at this hospital ?

Admission fees : \_\_\_\_\_) : Rs. \_\_\_\_\_

Bed rent (@ Rs. \_\_\_\_\_ per day) : Rs. \_\_\_\_\_

Medicines (namely, \_\_\_\_\_) : Rs. \_\_\_\_\_

Tests (namely, \_\_\_\_\_) : Rs. \_\_\_\_\_

Tips/bribes to ( \_\_\_\_\_ ) : Rs. \_\_\_\_\_

36. Please tell us whether you are satisfied with each of the services/facilities listed below :

Hospital Procedures/Facilities/Services	Level of satisfaction : Fully satisfied; Partly satisfied; Not satisfied
Procedures preceding admission	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Sleeping facility	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Hospital linen	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Hospital gown	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Hospital ward	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Toilets in the ward	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Food provided by the hospital	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Doctors of the hospital	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Nursing staff of the hospital	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Hospital wardboys	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>
Hospital ayahs	Fully satisfied <input type="checkbox"/> Somewhat satisfied <input type="checkbox"/> Not satisfied at all <input type="checkbox"/>

37. On the whole, are you satisfied with the care received from this hospital ? Why ?

\_\_\_\_\_

—

---

—

---

—

---

—

**38.** Would you return to this hospital the next time you need treatment? Under what circumstances? Why?

---

---

---

---

—

**39.** Would you recommend this hospital to your relatives/friends ? Under what circumstances ? Why ?

---

---

---

---

**40.** What improvements would you like to see in the hospital ?

---

---

---

---

—

Name of the interviewer: \_\_\_\_\_ Duration of interview:

\_\_\_\_\_

Comments: \_\_\_\_\_

**Annexure: 2**

**Study Of Patient Satisfaction In Lokmanya Tilak Municipal General Hospital**

Conducted by

**CEHAT**

Centre for *Enquiry* into *Health* and *Allied Themes*  
(*Research Centre of Anusandhan Trust*)

in collaboration with  
*The LTMG Hospital and the Sion Senior Citizens' Association*

**INFORMATION ON HOSPITAL WARDS**

(1)Ward No: \_\_\_\_\_

(2)Number of beds: \_\_\_\_\_

(3)Number of patients admitted (as of today): \_\_\_\_\_

**(4) Distribution of Beds and Patients admitted according to departments and units:**

Departments	Unit:				Unit:				Unit:			
	Beds		Patients		Beds		Patients		Beds		Patients	
	M	F	M	F	M	F	M	F	M	F	M	F

**(5) Ward Staff:**

Staff	Categories (if any)	Total Posts Sanctioned	Total No. Appointed	Vacancies	Number NOT Present		
					On Leave	On Deputation	Other
Nurses							
Wardboys							



<i>Ayas</i>						

***(6) Number and Availability of Selected Items in the Ward:***

Items	Total No. Supplied	No. in use as of today		No. NOT Available			
		In use	In reserve	Sent for cleaning	Sent for repairs	Not useable or discarded	other reasons
Mattresses							
Bedsheets							
Blankets							
Pillow covers							
Towels							
Bedpans							
Urinepots							
Spitoons							
Bedside tables							
Stools							
Stretchers							
Wheelchairs							
Oxygen Cylinders							

**Date:**

**Information given by: (name and designation):**