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A COMPARISON BETWEEN THE HOSPITAL CARE SERVICES, NURSING SERVICES AND DIETARY SERVICES OF SELECTED TWO HOSPITALS

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ABSTRACT

The major points of contact between the health-care delivery system of different hospitals agencies' regulatory and quality-control activities, health-care providers' illness surveillance and reporting, and the provision of safety-net services are all examples of these sectors. Although assurance is a core function of public health, government public health agencies often do more than ensure that people can access health care services; in areas where no other services are available for low-income, uninsured populations, and when managed care services to Medicaid and uninsured populations are discontinued, public health departments may become providers of last resort. Because of these circumstances, public health departments are forced to deliver personal health care services rather than using their resources and population-level techniques to lead and support community activities to improve health. Closer coordination and integration between two different hospitals agencies and the health-care delivery system could help both improve population health and support other public-health system players.

Key words: Public-Health, Hospital, Care Services, Nursing, Dietary Service.

INTRODUCTION

The word emergency clinic is gotten from the Latin word 'trusts,' which can allude to a guest or the host who invites them. The Latin 'Hospitalia,' a loft for outsiders or visitors, just as the archaic Latin 'Hospitale,' and the old French 'emergency clinic,' all started from 'Hospes.' In England all through the fifteenth century, it came to mean a house for the old or decrepit, just as a permanent place to stay for poor people. Hospice, neighborliness, cordial, host, inn, and lodging were all terms utilized in the

sixteenth century to depict medical clinics. The current meaning of an emergency clinic is an establishment that gives clinical or careful consideration to the debilitated or harmed. As such, a medical clinic is a design where the wiped out, harmed, or sick are invited and treated, just as an administrative or private organization set up for the gathering, fix, or sanctuary of individuals who are sick in body or psyche. Therefore, the essential and most significant occupation of an emergency clinic is to give skilled clinical consideration to the debilitated and harmed without respect for their social, monetary, or racial status.

CORPORATE HOSPITALS AND THE PRIVATE SECTOR

Since the 1970s, the quantity of corporate clinics has consistently expanded, making India a well-known medical services objective. The verifiable impact of the British, the absence of monetary and actual assets in the public medical services area, the rising interest for medical services from homegrown patients, the interest from global patients, lastly, India's financial development are the main impetuses behind the development of the private area in India. There are different force drivers for the ascent of private clinics, especially corporate clinics, notwithstanding the push factors (Express Health Care, 2008).

The British Influence

The British favored communist idea and free medical care, with the private area assuming just a minor part in serving the rich metropolitan populace or offering supplemental types of assistance. Subsequently, administrative spending represented 92% of the subsidizing, while private sources represented just 8%. (Baru, 1998). Notwithstanding, it fizzled inferable from an absence of subsidizing and political responsibility, and the public area started to give indications of disappointment. In 1961, Indian policymakers set up the Mudalier board, which supported the weaknesses of the state medical care framework and set up the private area as the authority entryway to noticeable quality (Baru, 1998).

Public Health Infrastructure That Isn't Up to Par-

As far as admittance to quality medical services offices, there is a critical provincial metropolitan hole; while a greater amount of the populace lives in country regions, the better medical services offices are

gathered in metropolitan regions. This is additionally exhibited by the way that only 25% of Indians approach allopathic medication, which is essentially rehearsed in metropolitan regions. The sickness profile is moving from transmittable infections to constant or way of life related illnesses because of quick financial turn of events, expanded urbanization, and rising expectations for everyday comforts. In any case, on the grounds that the public framework couldn't stay aware of the changing infection profiles in the Indian populace, private medical care administrations jumped up rapidly somewhat recently.

The Government's Financial Constraints

The focal government diminished the financing allotment for medical services in 1991, devastating the improvement of rustic wellbeing framework. Nonetheless, the public authority's approach seems to have supported the development of private emergency clinics in India. Moreover, as an enhancement to the Central Government Health Scheme, the public authority delivered a rundown of private medical clinics that could be utilized to get explicit administrations that were not open (or whose accessibility was postponed) in Government medical clinics or medical services offices in 1994. (CGHS). Many state legislatures are presently repaying the expenses of administrations given by private medical clinics under different projects. This recommends that the public authority will look for financing from the private area to make great optional and tertiary medical care offices. The asset lack was clear since India neglected to meet the Bhore board of trustees' proposal of apportioning 5% of GDP to medical care (Mathiyazhagan, 1999; Berman, 1998). The monetary drop of the 1970s exacerbated this monetary impediment. The measure of GDP spent on medical services has plunged to a disturbing 1.25 percent, delivering the general wellbeing framework totally deficient (Berman, 1998)

Government Assistance

During the 1980s and 1990s, the public authority utilized an assortment of ways to deal with allure private interest into the medical care industry.

- In 1969, banks were nationalized, and clinical consideration was perceived as an industry (Baru, 1998), clearing the way for bank credits to medical clinics.

- Import taxes on innovative clinical hardware were decreased, permitting medical clinics to buy the most modern innovation.
- Sactitioners, for instance, were allured by complete expense exclusion in the event that they treated 40% of their patients free of charge (Berman, 1998).
- In 1982, the National Health Policy was executed, underlining the need to open up clinical benefits to both for-benefit and non-benefit associations (Bhat, 1999).

Because of every one of the public authority's endeavors, corporate emergency clinics currently represent over 70% of India's metropolitan medical care market (Mudur, 2003).

The Middle Class Is Growing

With further developed buying power, India's working class developed to 40 to 50 million people (Bhat, 1999). They had the option to request and supporter for innovative, global standard emergency clinics (Mathiyazhagan, 2003; Qadeer, 2000). Since corporate clinics are regularly thought to be fit for accomplishing overall guidelines and proposition adaptability in area and booking to fit the comforts and needs of center pay gatherings, interest for corporate emergency clinics has developed altogether. Bhat et al., 1999).

The Grey Population Is Growing

Besides, since the 1950s, the public authority's endeavors to deal with the populace by empowering family arranging have brought about a decline in the more youthful populace. The older populace will develop by 2050, putting significantly more strain on people in general and private medical services areas.

Preference For Better and More Expensive Services

By 1999, clients were starting to pick private estimated administrations. At that point, around 85% of the administrations have been paid for from cash on hand. Roughly 20% of patients in OPDs the nation over have demonstrated that they like to go to a private office. Not with standing emerging from pocket costs, emergency clinics keep on flourishing (Nichter et al., 2000; Bhat, 1999). Truth be told, the

greater part of Mumbai's metropolitan populace has shown an inclination for corporate emergency clinics due to their predominant proficiency (Newbrander, 1997).

New Illnesses Have Emerged

Poor rustic travelers who live in ghettos or on the roads comprise general wellbeing hazards, bringing new contaminations and diseases into urban areas. Therefore, the metropolitan populace will confront a more intricate epidemiological example, requiring the utilization of further developed clinical innovations to fix infections. Beside the epidemiological example, the event of way of life sicknesses is on the ascent. As a result of the inexorably idle ways of life of the metropolitan working class, which accompanied the conveniences that innovation and success brought for the working class, illnesses like malignant growth, cardiovascular infection, and diabetes are starting to rise quickly (Qadeer, 2000). Since just corporate clinics will actually want to give treatment, the interest for corporate emergency clinics has soar (Mathiyazhagan, 2007).

RESEARCH METHODOLOGY

Sampling

A group of patients is chosen to collect data via questionnaire. A sample of patients from both hospitals was needed for the patient satisfaction survey. The sample consisted of in-patients who were scheduled to be discharged soon for three reasons —

- They will have worked with a variety of services.
- They are also available for contact during their free time, and
- They can be contacted over the phone to provide post-discharge perspectives on the hospital. The study was scheduled for a month between May and June of 2013. During that time, in-patients were approached and questionnaires were given to those who expressed an interest in participating in the study. After 2 or 3 days, the questionnaire was collected, allowing adequate time for respondents to provide answers in a calm way.

Given the constraints of cost and timing, each institution will secure a sample of 200 patients. During the field study period, each hospital receives about 250 surveys. The questionnaires that can be used for analysis are listed below.

Analyzing Data

The information from the completed surveys is tallied and evaluated using percentages, mean, and standard deviations. T-tests are used to determine the differences in patient satisfaction levels between two hospitals.

Table 1: Distribution on The Basis of Respondents' Marital Status

Categories	Apollo		Yashoda	
	f	%	f	%
Unmarried	95	63.33	105	61.76
Married	55	36.66	65	38.23
Total	150	100.0	170	100.0
Degrees of freedom=1	Chi-square value=1.396		Notsignificantat0.05level	

The people that responded are well-educated. They did, however, range from school dropouts to those who had completed their education after graduation. Table 4-4 reveals that patients with a college or graduate degree constitute the majority of replies in both circumstances. Their respective percentages are 50.0 and 43.33 for Apollo and 57.35 and 51.17 for Yashoda. Because the computed value of 1.873 is more than the table value of 5.99, the null hypothesis that there is no significant difference in education between Apollo and Yashoda respondents is accepted.

Table 2: Distribution on The Basis of Respondents' Occupation Status

Categories	Apollo		Yashoda	
	f	%	f	%
Private job	55	36.66	71	41.76
Government employee	22	14.66	32	18.82
Business	25	16.66	24	14.11
Farmers	41	27.33	38	22.35
Workers	7	4.66	5	2.94
Total	150	100.0	170	100.0
Degrees of freedom=4	Chi-square value=95.09		Significant at 0.05 level	

When it comes to incomes, which is one of the most important drivers of hospital choice, the responder patients are found to have a wide range of yearly earnings. Patients with monthly incomes of less than Rs.10,000 and more than Rs. 1 lakh make up a modest percentage of the sample, accounting for 6.66 percent in the case of Apollo and 10.66 percent in the case of the other. In the case of Yashoda, the percentages are greater, at 8 82% and 25.29 percent, respectively. Around 67.6% of Apollo patients and 50.9 percent of Yashoda patients earn between Rs.30001 and Rs.1 lakh each month. The null hypothesis that there is no significant difference in income between Apollo and Yashoda respondents is rejected because the table value of chi-square 9.488 is smaller than the computed value 13.4.

RESULTS AND DISCUSSION

Table 3: Distributions on The Basis of Moods Prior To Therapy

S. No	Statement	Apollo (N=150)		Yashoda (N=170)	
		f	%	f	%
1	Confident that my health problems will be resolved	133	63.3	137	62.3
2	Scared that the expenditure may be too high	96	45.7	98	44.5
3	Worried about comfort of attendant staying with me	79	37.6	88	40.0
4	Worried whether I get good care in the hospital	54	25.7	53	24.1

What happened as a result of your decision to join the hospital? Approximately 64.8 percent of Apollo hospital patients and 68.6 percent of Yashoda hospital patients had successful therapy. More than 50%, but fewer than 60%, of respondents at both hospitals said that (a) privacy is respected throughout treatment, and (b) dignity is maintained. Between 54.8 and 57.3 percent of patients agreed that they had made the best decision.

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Table 4: Distribution on The Basis of An Assessment of My Hospital of Choice

S. No	Process	Apollo (N=150)		Yashoda (N=170)	
		f	%	f	%
1	Treatment is successful	136	64.8	151	68.6
2	My privacy during treatment is safeguarded	109	51.9	123	55.9
3	My dignity as individual is protected	115	54.8	121	55.0
4	I am happy I have done the right choice of the hospital.	115	54.8	126	57.3

NURSING SERVICES

The nurses, after the doctors, are the ones who make the service work. In hospitals, how are nursing services rated? The ratings are shown in Tables. In Apollo hospitals, 44.1 percent of patients rate nurses as duty-conscious, and 50.7 percent rate them as capable. In the case of Yashoda hospitals, a similar ranking may be shown. Nurses chat and dealy services, according to more than 56% of responders from both hospitals. Around 70% of those polled said that nurses visit them on a regular basis.

Table 5: Distribution on The Basis of Nurses' Behaviour Points of View

View	Apollo(N=150)			Yashoda(N=170)		
	Yes	Sometimes/What	No	Yes	Sometimes/What	No
Nurses duty minded	44.1	28.3	24.1	45.5	28.7	21.1
Nurse is capable	50.7	27.3	18.3	49.0	31.1	16.5
Nurse chats And delays	55.1	0.0	42.5	57.0	0.0	40.6
Nurse visits regular	69.3	0.0	28.2	68.7	0.0	28.0

Table shows satisfaction ratings for nurses' services on a 5-point scale, with 5 indicating perfect satisfaction.

- **Medical Care** — Nurses act as professionals, attending to patients' needs and explaining procedures and other procedures to them.

- **Assistance -** They attend to patients, administer medications, and provide food at the appropriate times. They assist with bathing and using the bedpan.
- **Courtesy -** They are courteous to visitors and give instructions to the attendant.

The satisfaction scores for Apollo and Yashoda hospitals are 3.57 to 3.01 for Apollo and 3.50 to 3.93 for Yashoda, respectively. At the 0.05 level, the variations in mean ratings between Apollo and Yashoda are not significant. All of the computed numbers are less than the 1.96 in the table.

Table 6: Distribution on The Basis of Nursing Service Ratings

S. No	Aspect	Apollo (N=150)		Yashoda (N=170)		t-value
		Mean	SD	Mean	SD	
1	Professional approach of nursing staff	3.01	1.03	3.93	1.10	0.55
2	Nursing attention to the needs of patients	3.78	0.95	3.75	0.93	0.30
3	Explanation of procedures, tests and treatments	3.75	1.01	3.58	1.02	0.17
4	Wait time on call light/bell	3.66	1.10	3.65	1.09	1.69
5	Giving medicines at Proper timings	3.70	1.10	3.69	1.12	1.51
6	Consideration for family and visitors	3.67	1.06	3.51	1.06	0.07
7	Giving food at right time	3.70	1.03	3.77	1.10	0.56
8	Giving instructions with courtesy	3.57	1.06	3.50	1.01	0.67
9	Help in getting to the bathroom or in using a bedpan	3.65	1.11	3.57	1.18	0.78

On a scale of 1 to 5, Completely Satisfactory is the highest rating. 4 – Reasonably satisfactory 3- Unsatisfactory 2- Unsatisfactory 1- Extremely unsatisfactory (All the t- values are not significant at 0.05 kevel)

DIETARY SERVICES

The significance of nutritional services cannot be overstated. The opinions on dietary services provided to patients are shown in Table. More over half of the respondents believe the food is nutritious. However, the majority of responders said that meals was served late in both facilities. Table contains a more in-depth investigation. The respondents were presented with statements indicating hygiene, appearance, taste, flavor, temperature, and variety of food, and they expressed pleasure on all criteria. They were pleased because the diet was served on time and according to the doctor's directions. As a result, both hospitals' dietary services are satisfactory. At the 0.05 level, the variations in mean ratings between Apollo and Yashoda are not significant. All of the computed numbers are less than the 1.96 in the table.

Table -7: Distribution on The Basis of Dietary Services Opinions

View	Apollo (N=150)			Yashoda (N=170)		
	Yes	Sometimes /What	No	Yes	Sometimes/ What	No
Food nutritional	55.1	18.0	235	52.1	27.1	17.4
Served on time	47.0	21.6	28.0	45.6	23.0	28.0

Table-8: Distribution on The Basis of Dietary Service Ratings

S. No	Aspect	Apollo (N=150)		Yashoda (N=170)		t-value
		Mean	SD	Mean	SD	
1	Hygiene in serving of food	3.14	0.96	3.12	1.01	0.26
2	Appearance of food	3.83	0.82	3.80	0.83	0.35
3	Taste of food	3.71	1.03	3.58	1.06	1.34
4	Flavour of food	3.64	1.02	3.54	1.02	1.08
5	Temperature of food	3.72	1.10	3.59	1.14	1.25
6	Variety of food	3.41	1.06	3.35	1.06	0.56
7	Dietary counselling provided	3.64	1.13	3.51	1.15	1.14
8	Timely servicing of food	3.50	1.20	3.49	1.20	0.07

On a scale of 1 to 5, Completely Satisfactory is the highest rating. 4 – Reasonably satisfactory 3- Unsatisfactory 2- Unsatisfactory 1- Extremely unsatisfactory (All the t- values are not significant at 0.05 kevel).

CONCLUSION

In India, healthcare has shifted through the years from family doctors, local and community hospitals to business hospitals. In the tertiary sector, large hospital chains such as Fortis, Apollo, and Max add additional hospitals and beds. The major and business hospitals provide around 7% of bed capacity. The growing prevalence and poor quality of care in public hospitals of chronic lifestyle illnesses led even low middle-class people to spend more than their means. In recent years, the client has moved overwhelmingly to corporate hospitals. Another beneficial aspect is the establishment of corporate hospitals as favoured health clinics for foreigners. All these developments provide problems for corporate hospitals to maintain a high degree of service delivery for improving and maintaining image. They need operational excellence and efficiency in marketing in order to attract and satisfy patients. This study focuses on determining and evaluating the efficiency of marketing initiatives carried out by corporate hospitals.

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