



SELINUS UNIVERSITY
OF SCIENCES AND LITERATURE

**HOSPITAL MANAGEMENT AND PATIENT
SATISFACTION IN BANGLADESH:
A COMPARATIVE STUDY BETWEEN PRIVATE
AND PUBLIC SECTORS**

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A DISSERTATION

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Abstract

Health is a basic prerequisite for improving the quality of life. Socio-economic development of a nation mostly depends on the state of health. A large number of Bangladeshi people, particularly in rural areas, remain with no or little access to health care facilities. Their lack of participation in health service is a problem that has many dimensions and complexities.

Patient satisfaction with health care is seen as a dimension of quality of care. Expectations of service recipients are increasing day by day due to rapid development of science, technology and management. The quality of care that satisfied patients yesterday or day before yesterday may not satisfy them tomorrow or day after tomorrow. Moreover, satisfaction and utilization of services go hand in hand, which is the rationale behind thousands of satisfaction research being published in the developed world per year. But unfortunately, there is hardly any study on patient satisfaction using large series of field level data in Bangladesh. Finding clue from this gap this study has been done in order to evaluate patient satisfaction in Bangladesh.

A cross-sectional comparative study has been conducted with the aim of identifying differences in the level of satisfaction among patients in private and public hospitals. We have purposively selected six hospitals- three from public and three from private. Chattogram Medical College and Hospital, Chattogram 250 Bedded General Hospital and Bangladesh Institute of Tropical and infectious Diseases (BITID) are among the public hospitals and Chattogram Maa-O-Shishu General Hospital, International Islamic Medical College & Hospital and Bangabandhu Memorial Hospital (BMH) are from private hospital. Primary data will be collected through a structured pre-tested questionnaire from public hospitals and private hospitals. Half of the patients have been selected from medical wards and the other half from surgical wards. The list of patients ready to be released on a particular date has been obtained from the respective Ward-in-Charge of the respective hospitals.

Satisfaction score has been assessed with services of doctors, nurses, aya and ward boy, cleanliness, laboratory and reception. Satisfaction has been categorized into five levels- not at all satisfactory, somewhat satisfactory, more or less

satisfactory, appreciable, and excellent, where 1 meant for 'not at all satisfactory' and 5 for 'excellent', 'somewhat satisfactory' 2, 'more or less satisfactory' 3 and 'appreciable' 4 in between them. Dependent variable is satisfaction score. Satisfaction has been further assessed with a close question of future return to the same hospital. Inter personal perceptual variation has been taken into consideration to avoid confounding effect. Age, sex, occupation, educational status, socioeconomic condition, marital status, outcome of treatment, types of treatment and expenditure of treatment have also analyzed to measure the impact of these demographic characteristics on patient satisfaction. Data has been analyzed using SPSS version 20. Hypotheses have been tested using independent t test. Binary Logistic Regression Model has been built to explore maximum effect of independent variables on dependent variable. Qualitative data has been analyzed with Chi-square test, while one way ANOVA has been done to compare more than two groups.

One way ANOVA discovers that occupation and educational status of the study population have no influence on satisfaction. The rich people are more satisfied than the poor people. But age, sex, educational status, occupation, marital status and type of treatment has got no significant influence on satisfaction and future return to the same hospital. Even the amount of expenditure has not considered by the patients in determining their satisfaction in the same type of hospital. Outcome of treatment have logically influenced the satisfaction score. Those patients are more satisfied who are cured or improved than those who are deteriorated or died. Overall satisfaction is higher in private hospitals than that of public hospitals in respect of all services - doctor, nurse, aya/ward boy and cleaner, laboratory services, reception and medicine supply. Availability of essential service, politeness and sympathy of staff, cleanliness, and use of modern equipment has positive influence on patient satisfaction in private hospitals.

It is surprising that expenditure of treatment does not influence the satisfaction rather the services of doctor, nurse, aya/ward boy and cleaner, reception, laboratory and cleanliness have influenced the satisfaction score. It indicates patients require service even if it requires reasonable costs.

Around 30 percent of the respondents are disappointed with the services. They will not return to the same hospital for consuming service if they would become ill unluckily. It is only the services provided by the hospital that could influence the patient significantly in making decision of future return to the same hospital. But binary logistic regression analysis explores that future return depends on doctor's service, Aya/ ward boy and cleaner's service, regular and timely supply of medicines only. Nurse's service, reception, laboratory service, cleanliness and outcome of treatment do not influence the decision significantly.

Most of the people of Bangladesh are of poor socio-economic status and they have to avail themselves of the services from public sector. But it is frustrating that most of the services provide by public providers are not at all satisfactory to a good number of the patients. It gives a red signal for the health system of the country. Till now public sector is the only active system at the doorstep level of the poor and middle-class people. Most of the people cannot buy the health services of private sector as they are costly. So, it is urgently needed to identify the loopholes of the public sector and fix accountability of the service providers. Besides, the cost of services of the private providers should be reasonable to all segments of the society and the Directorate of Health should influence the price fixing mechanism of the private hospitals.

Now a days, there is a common headline of the daily newspapers that hospitals and health centers are beset with various problems, making it difficult to provide medical care services to the patients. It is a known fact that there is mismanagement, lack of proper coordination, problems of supervision and accountability aggravate the problems, essential supplies are generally unavailable, facilities are inadequate, and the quality of staffing is poor, while corrupt practices seem to be on the increase as media reports indicate weak monitoring and supervisory framework, centralized management, poor management of drug and lack of modern equipment in the health administration. Ex-ray machines and ambulances are out of order most of the time. Uncontrolled trade union is one of the main reasons for this. Thus it becomes difficult for the administration to take action against their corrupt practices and irregularity in the services. Taking more money for ticket from out-door patient, absence of senior doctors in the outdoor department, corruption in admission of

indoor patient, lack of sympathy for patients among the doctors and nurses make the health service inaccessible to the beneficiaries. From various observations it has become clear that the Government is not able to provide required health service to the people and people's participation in the public health service is even at the basic level.

Bangladesh, with about 182.2 million people in only 147,570 sq. km, is one of the densely-populated countries in the world. Its problems are many and health is one of them. Poor and inadequate health services are acting as obstacles against the overall development of this country. Health service is one of the most important sectors to fulfill the fundamental rights of the people of a country. It is the constitutional binding of the state to ensure adequate health service delivery to the people (Bangladesh Constitution, Article-18). Moreover, as a signatory to Alma Ata Declaration 1978, Bangladesh is committed to providing appropriate health services to its citizens (Fardaus, 2008). However, this grand vision of primary health care for all has not yet been achieved. On the contrary, Basic primary health care services are not made accessible equally and the marginalized people of rural Bangladesh are treated in a highly discriminatory nature to have access to health facilities.

There are already a number of awareness programs focusing on health issues that are being implemented by the development agencies in rural Bangladesh. In spite of some very rare exceptions, all the health awareness programs have aimed at improving the knowledge level on health and hygiene issues. They have not been aimed at promoting the right for all to have access to primary health care facilities. Very often, the common people think that they are lucky to get some access to health services (no matter how small an amount they receive). They do not demand equitable access to health facilities. The problem of access to health care is particularly acute in Bangladesh. According to the World Bank (1987) estimate, 'only 30 percent of the population of Bangladesh has access to primary health services and overall health care performance remains unacceptably low by all conventional measurements.' A subsequent study of Sen and Acharya (1997) notes some improvements but indicates that the poor quality of health services is a persistent concern.

In this situation, too many corrupt doctors do not serve the common people well,

take bribe, and do not maintain office time at the public health centers. Instead, they prefer to run private clinics for their own profit during their office time. Such malpractice generally starts from the moment of posting of a doctor to a rural THC or Union Health Centre. They are either unwilling to join, or they make delay within the loopholes of the system. Given the doctors who join the THCs in rural areas, being dissatisfied with working conditions and career prospects, lack of alternative ways of earning extra money through private practice, they provide service for lesser time than the scheduled working hour. Neglect of duties of the paramedics and domiciliary staff has also been affecting the policy implementation process (Osman & Ferdous 2004). No positive affirmative action is seen to resolve this problem. Of course, not all doctors are corrupt, but this is a common picture in most rural areas. Common people most often do not protest against this simply because they lack consciousness about their rights.

Faced with this growing dissatisfaction, the private health care sector (including unqualified providers) are growing rapidly and presently about 70 percent of the patients seeking medical care from this sector (World Bank, 2003). Between 1996 and 2000, private hospitals grew around 15 percent per annum (HEU, 2003). Unfortunately, there are concerns that the quality of the private health care service is also being ignored. Some of its main drawbacks include disregard of standard treatment protocols, lack of qualified nurses and unnecessary diagnostic tests (World Bank, 2003).

Bangladesh Government and its development partners have also acknowledged their concerns about the quality of health care services leading to poor health care system (MOHFW, 2003). These instances reflect the problems of health service delivery system that must be addressed quickly. With the quality of services showing little signs of improvement, a large number of Bangladeshi patients who are able to afford it are going to foreign hospitals, despite the financial costs and the cumbersome processes involved in getting visas, obtaining foreign exchange, arranging for transportation, accommodation and food, and finding the right providers. This situation clearly indicates that the perceived benefits either from public or private (in particular public) to them are not satisfactory to service costs incurred. This also results in huge losses of foreign exchange for Bangladesh,

estimated approximately Tk. 500 million a year on foreign health care services according to the official record of the Institute of Health Economics, University of Dhaka, Bangladesh (IHE 2002). Thus there are problems of access, cost, and services which in turn affect the level of patient satisfaction both in public and private hospitals in Bangladesh.

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Table of Contents

Certificate-----	i
Declaration-----	ii
Acknowledgement-----	iii
Abbreviation-----	v
Contents-----	vii
List of Tables-----	xii
List of Figures-----	xiv
Abstract-----	xv

Chapter 1: Introduction and Aim of Study

1.1 Background of the Study

1.2 Statement of the problem

1.3 Research Objective/Aim

1.3.1 Specific Objective

1.4 Research question

1.5 Significance of the Study

1.6 Scope of the Study

1.7 Organization of the Study

Chapter 2: Literature Review

Chapter 3: Data and Methodology

3.1 Conceptual Framework

3.2 Study Design

3.3 Study Population and area

3.4 Study Period

3.5 Sample Size Calculation

3.6 Inclusion Criteria

3.7 Exclusion Criteria

3.8 Sample Techniques

3.9 Data Collection Tools

3.10 Data Management and Analysis Plan

3.11 Ethical Considerations

3.12 Quality Control

3.13 Expected Outcome

3.14 Flow Chart of Cross -Sectional Study

3.15 Time line of the Study

Chapter 4: Contents and Results

Chapter 5: Discussion

Chapter 6: Conclusion

Appendices

Bibliography

List of Table and Figures

Table	Hospitals by Bed Capacity and total Beds	Page
2.1	Basic Information of Some Private and Autonomous Hospitals in Bangladesh.	
2.2	Basic Information about the Selected Hospitals	
4.1	Demographic Characteristics of the Selected Patients	
4.2	Comparative Scenario of Educational Status of the Respondents	
4.3	Comparative Scenario of Marital Status of the Respondents	
4.4	Occupation of the Respondents	
4.5	Comparative Scenario of Socio-economic Status of the Respondents	
4.6	Comparative Scenario of Outcome of Treatment	
4.8	Comparative Scenario of Duration of Hospital Stay	
5.1	Patient Satisfaction Score of the Selected Hospitals	
5.2	Satisfaction Score of Different Independent Variables	
5.3	Satisfaction Score of Different Age Group	
5.4	Satisfaction Score of both the Sexes	
5.5	Comparison of Satisfaction Score between Private and Public Sectors	
5.6	Satisfaction Score based on Educational Status	
5.7	Difference in Satisfaction Score between Married and Unmarried Patients	
5.8	Difference in Satisfaction Score based on Marital Status	
5.9	Satisfaction Scores of different Occupations	
5.10	Satisfaction Score based on Socio-economic Status	
5.11	Satisfaction Score Based on Outcome of Treatment	
5.12	Correlation between Duration of Hospital Stay and Satisfaction Score	
5.13	Correlation between Hospital Stay and Satisfaction Score between Private and Public Sectors	

5.14	Correlation between total Expenditure and Satisfaction Score	
6.1	Satisfaction Score Influencing Future Return Group Statistics	
6.2	Factors Influencing Future Return to the Same Hospital	
6.3	Influence of Educational Status on Future Return to the Same Hospital	
6.4	Influence of Marital Status on Future Return to the Same Hospital	
6.5	Influence of Socio-economic Status on Future Return to the Same Hospital	
6.6	Influence of Occupations on Future Return to the Same Hospital	
6.7	Influence of type of Treatment on Future Return to the Same Hospital	
6.8	Binary Logistic Regression Analysis for Future Return to the Same Hospital	
7.1	Satisfaction Score of the Selected Six Hospitals	
7.2	Comparison of Satisfaction Scores of Different Services at a Glance	
7.3	Comparison of Doctor's Service between Private and Public Hospitals	
7.4	Different Parameters of Doctor's Service in Private and Public Hospitals	
7.5	Comparison of Doctor's Services among the Selected Hospitals	
7.6	Satisfaction Scores of Different Elements of Doctor's Services	
7.7	Comparison of Nursing Service between Private and Public Hospitals	
7.8	Evaluation of Nursing Services by the Patients	
7.9	Comparison of Nursing Services among the Selected Hospitals	
7.10	Satisfaction Scores of Different Elements of Nursing Services	
7.11	Comparison of Services of Aya/ Ward Boy and Cleaner	
7.12	Evaluation of Aya/ Ward Boy and Cleaner Services by the Patients	
7.13	Comparison of Cleanliness Service in Private and Public Hospitals	
7.14	Timely Medicine to the Patients	

7.15	Medicine Supply as Required Quantity	
7.16	Comparison of Satisfaction Score among the Selected Hospitals	
7.17	Comparison between Private and Public Hospitals Regarding Medicine Supply	
7.18	Evaluation of Reception Services in Private Hospitals by the Patients	
7.19	Evaluation of Laboratory Services of Public Hospitals by the Patients	
7.20	Evaluation of Laboratory Services of Private Hospitals by the Patients	
7.21	Descriptive Statistics of the Laboratory Services	
7.22	Comparison of Parameters of Laboratory Services	

Chapter 1 Introduction & Aim of the Study

Health is a basic requirement for improving the quality of life. Economic and social development of a nation mostly depends on the state of health. The health sector occupies an enormously important position to ensure sustainable overall socio-economic advancement in developing countries. In Bangladesh, the government has begun to integrate strategically the health sector into its poverty reduction plans, for an unhealthy nation is meant to continue a vicious circle of poverty. In this regard, the Commission on Macroeconomics and Health (2001) asserts that 'improving the health and longevity of the poor is amend in itself, a fundamental goal of economic development'.

The health care system in Bangladesh is a mixture of public and private initiatives. In terms of physical infrastructure, public sector is stronger than the private sector although in terms of coverage, the health care system of the country should be termed as a privatized one. Besides, there are some NGOs, which also play a significant role in providing health services. All these institutions are managed and controlled under the policy guidelines of the government (Osman & Ferdous, 2004).

In Bangladesh, government is viewed as the primary actor in the health sector. The overall health status in Bangladesh represents an unimpressive picture though some developments have taken place in this sector during the past years. The country has adopted primary health care policy for achieving health for all, but achievement in the health sector is very poor. Social and economic inequalities exist to the highest extent in Bangladesh. Medical care is an extremely scarce and expensive service in the country. The Government delivery system is not efficient enough to cover the target population.

The government's efforts to provide health facilities at various levels, though free of cost and managed by trained professionals, has however, not led to desired level of use of the services. Primary health care services are greatly underutilized, despite concerted efforts employed by the government to improve these services (Jahan et al., 2006).

The health care service in Bangladesh is provided in a three-tier system: primary, secondary and tertiary tiers. Population per physician is 3269 and population per bed (beds of health sector + registered private hospitals) is 1860 and there are 38,171

public hospital beds and 36,244 private hospital beds (DGHS, 2010). Rate of increase of hospital beds was 11.9 percent during the years 1990-95 and 8.4 percent during the years 1995-2000. Population growth rate is 1.40 percent. District hospitals are over- utilized (in-patient) by 52.62 percent -71.97 percent but Upazilla hospitals are remaining underutilized by 80.76 percent-60.3 percent which suggest that people are inclined more towards using the services at the secondary and above levels, while at the primary level the services remain underutilized. This flows from the perceived idea of the people regarding quality of service provided at different tiers. Social acceptability is an important dimension of quality of care and it encompasses patient satisfaction in it (Bangladesh Health Service,1990).

Bangladesh has a good healthcare network covering both rural and urban areas. Directorate General of Health Services (2012) recent report shows that there are 3,976 healthcare facilities in the public sector and 2966 privately run hospitals/clinics. The healthcare-delivery system of the country compares favorably with that of many other Asian countries. However, overall healthcare utilization in Bangladesh is low and is of great concern to society. A survey by the Centre for International Epidemiological Training (CIET, 2003), showed that, in Bangladesh, 13 percent of treatment-seekers use government services, 27 percent use private / NGO services, and 60 percent unqualified services (Cockcroft et al., 2004). In their comparative survey on private and public healthcare providers in Bangladesh, Ricardo et al. observed that the overall use- rate for public healthcare services was as low as 30 percent (World Bank, 2005). On the other hand, the uneven distribution of demand is creating unmanageable pressure on a few reputed public hospitals. In their 'Bangladesh healthcare facility efficiency study', Rannan and Samantha (1997) stated that the overall patient load in public medical college hospitals was approximately five times higher than that in other general hospitals.

Andaleeb (2001) has mentioned that the health care delivery system in Bangladesh faces three major challenges: improving quality, increasing access and reducing cost. There is growing evidence that the perceived quality of medical care services has a relatively greater influence on patient behaviors (satisfaction, referrals, choice, usage, etc) compared to access and cost. In Nepal, for example, the government made substantial investments in basic health care to increase access. Yet, according

to Lafond (1995), utilization of the facilities remained low because of clients' negative perception of quality. Guldner and Rifkin (1993) also showed that in Vietnam and Uganda, poor quality of services in the public sector led to greater use of private providers.

A large number of Bangladeshi people, particularly in rural areas, remained with no or little access to health care facilities. Lack of participation in health service is a problem that has many dimensions and complexities. But it is alleged that the present health policy is not people oriented. Financial and technical support is very helpful to ensure health service among village people. However, the Government allocates only 5 percent of the budget to the health sector, while it allocates 13 percent to defense sector. The World Health Organization (2006) has identified that about 50 percent of the medical equipment in developing countries is unusable.

The efforts of the government, NGOs and private service providers in the country's health sector have been rewarded with some success, especially in primary health care with its focus on prevention. Presently, 73 percent of children are fully immunized in Bangladesh (NIPORT 2004) and the under-five mortality has reduced to 53 per 1000 live births in 2011 from 88 per 1000 live births in 2004 (BDHS, 2011). The infant mortality rate has also declined to 42 per 1000 live-births in 2011 from 65 per 1000 live births in 2004. Maternal mortality, an important indicator of well-being, has also declined to 1.94 per 1000 in 2011 from 4.8 per 1000 in the 1990s, with the introduction of appropriate preventive measures (BDHS, 2011).

There are huge differences between expectations and services in health care delivery in Bangladesh. Even after these limitations described above, every human being expects that in case of his/her falling sick he/she will be taken to a qualified health practitioner or hospital in the quickest possible time, where he/she will be welcomed. It will be expected that hospital personnel will speak in the same or an understandable language and are courteous & caring. It may also be expected that they will have keen interest in treating patient, create homely and comfortable environment and provide for best investigation facilities and competent care ensuring quickest recovery. Patients expect that they will not have to wait for treatment, which will be free of cost or at an affordable cost and at every stage of decision making about the care opinion of the patients will be given due importance. When these

expectations are met, a sense of satisfaction prevails in the mind and body of the patient and the same in turn quickens recovery. Satisfaction with hospital care is an outcome of hospital experience and is the result of individual evaluation by the patient of the multiple attributes of care in the background of his/her personal characteristics.

Health care service delivery, like any other service, depends on the interaction between two parties- the provider and the client or consumer of the service. The interaction determines the level of utilization of the service by the individuals, group of the community. If a balance could be achieved between the demands of the client and the supply by the providers of service then an optimum utilization results. The level of health of a nation is, to a great extent, determined by the level of utilization of its health care services by its people.

From the days of inception of the understandings of quality of care, doctors used to evaluate the service rendered by them through setting certain standards of their performance and comparing actual performance with the standard set. There was no reflection of opinion of the recipients of services. Presently patients' opinion about medical services, received from hospitals or individual service providers is given due importance as it shapes attitude of the recipients about future utilization of the services.

Charles (1994) stated that 'patient satisfaction' with health care is seen as a dimension of quality of care. Patient satisfaction was defined as a health care recipient's reaction to salient aspects of the context, process and result of their service experience. Fitzpatrick (1991) commented, 'discussion about how the quality of health care should be measured increasingly includes patient satisfaction as one of the important dimensions of health care. Satisfaction ratings reflect three variables: the personal preferences of the patient, the patient's expectations and the realities of care received. Satisfaction with the realities of care received is affected by many different components of that care-access, cost, competence of care, personal qualities of service providers, participation of patient in decision making about his/her own care, provision of information about the disease, results of investigation, physical care, catering aspects of hospital care, etc. Again, satisfaction level of patient will vary depending upon the expectations of and evaluations by the patient,

which is determined by the socio- cultural background, age, economic status, educational qualifications, previous experience of hospital stay, severity of illness, etc. Patient variables including patient characteristics and expectations are often referred to as determinants of satisfaction, while care variables are referred to as the components of satisfaction.

Aim of the study

The main objective of the study is to make a comparative evaluation of the services provided by the private and the public hospitals in terms of patient satisfaction. The specific objectives of the study are as follows:

- To identify the basic characteristics of patients in Bangladesh.
- To examine and evaluate the level of patient satisfaction along with influencing factors both in public and private hospitals.
- To compare and contrast between the level of patient satisfaction in public and private hospitals.
- To justify different socio-demographic factors influencing the level of patient satisfaction.
- To examine either patient satisfaction score or socio-demographic characteristics influence his/her decision making on his/her return to the same hospital.

1.1 Background of the study

Health is a basic prerequisite for improving the quality of life. Socio-economic development of a nation mostly depends on the state of health. A large number of Bangladeshi people, particularly in rural areas, remain with no or little access to health care facilities. Their lack of participation in health service is a problem that has many dimensions and complexities.

Patient satisfaction with health care is seen as a dimension of quality of care. Expectations of service recipients are increasing day by day due to rapid development of science, technology and management. The quality of care that satisfied patients yesterday or day before yesterday may not satisfy them tomorrow or day after tomorrow. Moreover, satisfaction and utilization of services go hand in hand, which is the rationale behind thousands of satisfaction research being published in the developed world per year. But unfortunately, there is hardly any study on patient satisfaction using large series of field level data in Bangladesh. Finding clue from this gap this study has been done in order to evaluate patient satisfaction in Bangladesh.

1.1 Statement of the Problem

Bangladesh, with about 170.00 million people in only 147,570 sq. km, is one of the densely-populated countries in the world. Its problems are many and health is one of them. Poor and inadequate health services are acting as obstacles against the overall development of this country. Health service is one of the most important sectors to fulfill the fundamental rights of the people of a country. It is the constitutional binding of the state to ensure adequate health service delivery to the people (Bangladesh Constitution, Article-18). Moreover, as a signatory to Alma Ata Declaration 1978, Bangladesh is committed to providing appropriate health services to its citizens (Fardaus, 2008). However, this grand vision of primary health care for all has not yet been achieved. On the contrary, Basic primary health care services are not made accessible equally and the marginalized people of rural Bangladesh are treated in a highly discriminatory nature to have access to health facilities.

There are already a number of awareness programs focusing on health issues that are being implemented by the development agencies in rural Bangladesh. In spite of some very rare exceptions, all the health awareness programs have aimed at improving the knowledge level on health and hygiene issues. They have not been aimed at promoting the right for all to have access to primary health care facilities. Very often, the common people think that they are lucky to get some access to health services (no matter how small an amount they receive). They do not demand equitable access to health facilities. The problem of access to health care is particularly acute in Bangladesh. According to the World Bank (1987) estimate, 'only 30 percent of the population of Bangladesh has access to primary health services and overall health care performance remains unacceptably low by all conventional measurements.' A subsequent study of Sen and Acharya (1997) notes some improvements but indicates that the poor quality of health services is a persistent concern.

Now a days, there is a common headline of the daily newspapers that hospitals and health centers are beset with various problems, making it difficult to provide medical care services to the patients. It is a known fact that there is mismanagement, lack of proper coordination, problems of supervision and accountability aggravate the problems, essential supplies are generally unavailable, facilities are inadequate, and

the quality of staffing is poor, while corrupt practices seem to be on the increase as media reports indicate weak monitoring and supervisory framework, centralized management, poor management of drug and lack of modern equipment in the health administration. X-ray machines and ambulances are out of order most of the time. Uncontrolled trade union is one of the main reasons for this. Thus, it becomes difficult for the administration to take action against their corrupt practices and irregularity in the services. Taking more money for ticket from out-door patient, absence of senior doctors in the outdoor department, corruption in admission of indoor patient, lack of sympathy for patients among the doctors and nurses make the health service inaccessible to the beneficiaries. From various observations it has become clear that the Government is not able to provide required health service to the people and people's participation in the public health service is even at the basic level.

In this situation, too many corrupt doctors do not serve the common people well, take bribe, and do not maintain office time at the public health centers. Instead, they prefer to run private clinics for their own profit during their office time. Such malpractice generally starts from the moment of posting of a doctor to a rural THC or Union Health Centre. They are either unwilling to join, or they make delay within the loopholes of the system. Given the doctors who join the THCs in rural areas, being dissatisfied with working conditions and career prospects, lack of alternative ways of earning extra money through private practice, they provide service for lesser time than the scheduled working hour. Neglect of duties of the paramedics and domiciliary staff has also been affecting the policy implementation process (Osman & Ferdous 2004). No positive affirmative action is seen to resolve this problem. Of course, not all doctors are corrupt, but this is a common picture in most rural areas. Common people most often do not protest against this simply because they lack consciousness about their rights.

Faced with this growing dissatisfaction, the private health care sectors (including unqualified providers) are growing rapidly and presently about 70 percent of the patients seeking medical care from this sector (World Bank, 2003). Between 1996 and 2000, private hospitals grew around 15 percent per annum (HEU, 2003). Unfortunately, there are concerns that the quality of the private health care service is

also being ignored. Some of its main drawbacks include disregard of standard treatment protocols, lack of qualified nurses and unnecessary diagnostic tests (World Bank, 2003).

Bangladesh Government and its development partners have also acknowledged their concerns about the quality of health care services leading to poor health care system (MOHFW, 2003). These instances reflect the problems of health service delivery system that must be addressed quickly. With the quality of services showing little signs of improvement, a large number of Bangladeshi patients who are able to afford it are going to foreign hospitals, despite the financial costs and the cumbersome processes involved in getting visas, obtaining foreign exchange, arranging for transportation, accommodation and food, and finding the right providers. This situation clearly indicates that the perceived benefits either from public or private (in particular public) to them are not satisfactory to service costs incurred. This also results in huge losses of foreign exchange for Bangladesh, estimated approximately Tk. 500 million a year on foreign health care services according to the official record of the Institute of Health Economics, University of Dhaka, Bangladesh (IHE 2002). Thus, there are problems of access, cost, and services which in turn affect the level of patient satisfaction both in public and private hospitals in Bangladesh.

1.2 Research Objective/Aim

1.2.1 specific Objective:

1. To evaluate the implementation of Total Quality Management (TQM) practices in selected private and public hospitals in Chattogram City.

This objective aims to analyze the level of TQM adoption in both private and public hospitals, including key TQM principles such as leadership, customer focus, process management, and continuous improvement.

2. To assess the impact of TQM practices on patient satisfaction in both private and public hospitals.

This will focus on identifying how various TQM practices influence the experience and satisfaction of patients in these hospitals, comparing the effectiveness between public and private sectors.

3. To identify the differences in service quality between private and public hospitals in Chattogram City, as perceived by patients.

This objective aims to determine the variance in service quality in both sectors, specifically looking at factors such as responsiveness, assurance, empathy, tangibles, and reliability, as they relate to patient satisfaction.

4. To examine the relationship between hospital staff training and development and the quality of care provided in both sectors.

This explores how well-trained staff, a key component of TQM, contributes to better patient outcomes and satisfaction in both private and public hospitals.

5. To investigate the role of hospital infrastructure and technology in improving hospital system quality and patient satisfaction.

This objective would focus on how infrastructure improvements and technological advancements play a role in enhancing both the quality of hospital services and overall patient satisfaction in both types of hospitals.

6. To explore the challenges and barriers faced by public and private hospitals in Chattogram City in implementing TQM practices.

This will identify the difficulties that hospitals encounter in adopting TQM practices and how they affect service quality and patient satisfaction.

7. To compare the effectiveness of management strategies in private and

public hospitals regarding the implementation of TQM principles.

This would analyze how management in both hospital types integrates TQM principles into hospital operations and the resulting patient satisfaction levels.

8. To propose recommendations for improving TQM practices and patient satisfaction in public and private hospitals in Chattogram City.

Based on the findings of my research, I will provide actionable recommendations to enhance hospital services, quality management practices, and ultimately, patient satisfaction.

These objectives will guide my research process and ensure that my study addresses both the theoretical and practical implications of TQM in hospitals, with a focus on patient satisfaction in the context of Chattogram.

1.3 Research Question

The following questions were exposed before the researcher after review of available literature, which have been answered through this study:

1. What are the factors responsible for variation of patient's satisfaction level in Bangladesh?
2. Is there any variation of patient's satisfaction score between private and public hospitals in Bangladesh?
3. What are the factors that can influence patient's future return decision to the same hospital?
4. Whether the findings of previous researches support the findings of the present study?

1.3 Significance of the Study

The health system in Bangladesh is recently in a serious questionable position. Dissatisfaction of the patients against health care centers is a common scenario in every health care delivery center. This particularly applies to public health care centers and hospitals. As a consequence, the poor people are becoming frustrated, depressed and annoyed leading to poor utilization of the system. Sometimes their dissatisfaction turns into anger leading to vandalize the hospitals. There are huge studies regarding patient satisfaction abroad. But this major issue is not yet effectively addressed in our country. Patient satisfaction and consumer feedback can contribute to the planning and implementing a cost-effective care for all walks of life.

Cost of health care is key concern for the patients receiving the service. In the public health sector, the cost is low but service delivery is inefficient. Many of the services are not provided at all; where as in the private health sector almost all services are provided. But the cost is too high to be afforded by many of its clients. Sometimes they have to pay bill at the cost of their household assets. Thus, the poor are getting even poor which is unfortunate for the total economy of the country. Besides there are other factors as well which need to be identified and addressed effectively in order provide a health care which satisfies its client from all perspectives

This study, therefore, focuses on difference in patients' satisfaction in private and public hospitals and in order to identify the factors associated with patient satisfaction. The study intends to evaluate the different services provided by private and public hospitals and seeks to correlate them with level of patient satisfaction.

In a hospital, patients receive the services from doctors, nurses, aya/ word boy and cleaners on the ground of prescriptions, suggestion, nursing care, cleanliness and hospitality. Our health care systems are delivering services, but patients to these services are always ignored. Service delivery system rarely bothers for attitude, needs or opinions of the patients. This study would take the service system in the court of consumers. The consumers (patients) will justify the system and will compare the services between public and private hospitals.

The study will contribute to the existing stock of knowledge and to the improvement of satisfaction level of the patients both in public and private hospitals. Till date there is hardly any in-depth study to measure the satisfaction level of the patients in Bangladesh. The data generated from the study would be useful for:

- The planners and policy-makers for making appropriate policies to improve the situation prevailing in both private and public hospitals in Bangladesh.
- The managers of the hospitals to implement those policies in most efficient way possible.
- The researchers of this field and related fields to undertake further study to fill in the gaps in information in the concerned discipline.
- The academicians will get an insight into the realities of the problem of poor satisfaction level of the patients.

1.6 Scope of the Study

This study aims to examine the relationship between Total Quality Management (TQM) practices and patient satisfaction within the context of the hospital systems in Bangladesh, specifically focusing on Chattogram city. The scope of this study is outlined as follows:

1. Geographical Scope:

The research will be conducted in the city of Chattogram, one of Bangladesh's major urban centers. Chattogram is home to a mix of private and public hospitals, making it an ideal setting for comparing how TQM practices are implemented in different types of healthcare institutions. This study will focus on selected private and public hospitals in the city, with emphasis on understanding the healthcare management practices, patient satisfaction, and service delivery in these institutions.

2. Institutional Scope:

The study will include a comparative analysis between selective private and public hospitals. The selected private hospitals will represent high-end healthcare providers, while public hospitals will represent those that cater to a larger portion of the population, often facing resource constraints. The research will cover several hospitals within both sectors to capture a comprehensive view of the TQM practices and their effects on patient satisfaction in each type of institution.

3. Subject Scope:

The primary focus of the study will be on Total Quality Management (TQM) practices within the hospital systems. TQM is characterized by strategies such as continuous improvement, patient-focused care, leadership involvement, employee engagement, and data-driven decision-making. This study will examine how these practices are implemented in the selected hospitals and how they influence patient satisfaction.

The study will specifically assess:

- a) TQM dimensions such as leadership, process management, and customer satisfaction in healthcare.

b) Patient satisfaction factors including the quality of medical care, hospital environment, staff interaction, waiting times, and overall service delivery.

4. Temporal Scope:

This study will focus on data collected over a defined period during the year 2025. Patient satisfaction surveys and interviews with hospital management, staff, and patients will be conducted within this time frame, ensuring the findings reflect the current status of TQM implementation and patient satisfaction in Chattogram's healthcare system.

5. Limitations:

The study will be limited to only a few selected public and private hospitals in Chattogram, rather than all hospitals in the city or country. This limitation may impact the generalizability of the findings but ensures a manageable sample size for a detailed comparative analysis. Additionally, the study will focus primarily on TQM practices related to patient satisfaction, excluding other management factors such as financial sustainability or administrative efficiency, which may also influence hospital performance.

6. Target Respondents:

The target respondents for this study will include:

- Hospital administrators and managers to gain insights into the implementation of TQM strategies.
- Medical and non-medical staff to assess their role in the execution of quality management practices.
- Patients (current and discharged) to evaluate their level of satisfaction with the healthcare services provided.

By focusing on these aspects, this study seeks to provide a comparative analysis of how TQM practices are adopted and their impact on patient satisfaction in both public and private hospitals in Chattogram city.

1.6 Organization of the Study

The study is divided into three parts- Part A, Part B, and Part C.

Part A presents the theoretical aspects of the study containing four chapters specifically, introduction, hospital management scenario in Bangladesh, methodology of the study and theoretical framework.

The first chapter mainly includes statement of the problem, review of literature, research gap, research questions, objectives, rationale of the study, scope, and limitations of the study.

The second chapter presents role of hospital, factors affecting utilization of the hospital services, functions, managerial roles, skills of hospital administrator, history of health services, organizational structure of health care service, hospital and primary health care, deficiencies of public health care services, public and private sectors in Bangladesh, citizen's charter for hospital services, doctor- patient, doctor-nurse relationship, nurses-patient relationship.

The third chapter presents concept of patient satisfaction, dimension of patient satisfaction, components of satisfaction, patient characteristics and interpersonal aspects of care, operational definitions of key terms and variables, hospital services, additional factors, and a diagram of conceptual framework of the study.

The fourth chapter presents methodological aspects of the study and mainly includes type, period, and hypothesis of the study, selection of sample hospitals, selection of respondents, methods of data collection, data processing and statistical tools for data analysis, questionnaire and scale used, explanation of basic characteristics of population.

Part B presents the core chapters of the study and contains four chapters. The researcher tried to answer all the research questions and validated research hypotheses. This is the main analytical part of study, which presents discussion of results.

Part C presents only one chapter namely summary of findings, conclusions and recommendations of the study. This chapter also includes direction for future studies in this area.

CAPTER-2: Review of Literature

Williamson (1971) stated that the evaluation of patient care requires the consideration of hundreds of variables. It is the fact which has probably discouraged investigators from applying much effort in this area. The strategy to solve this problem is focusing on those factors that might have the greatest probability of effecting significant improvement in the health status of a target population. The four elements of this strategy are: diagnostic outcomes (or results), diagnostic process (or actions), therapeutic outcomes (or results), and therapeutic process (or actions). It is to be noted that these factors are listed in order of their priority for evaluation and not in their chronological sequence in clinical practice. Diagnostic outcomes represent the data required to determine the need for care, specific therapy, and prognosis. It could be a simple diagnosis derived from a single symptom or laboratory test or a complex diagnosis with major treatment and prognostic implications. Therapeutic outcomes represent the health status of the patient at a given period of time following treatment (lived or died, remained ambulatory or was bed-ridden, returned to work, or remained dependent etc). Diagnostic process includes the procedures carried out in order to furnish the physician with the facts on which to base his diagnosis (history taking, physical examination, ordering laboratory tests, analyzing data, arriving at a diagnostic synthesis). Therapeutic process includes planning, implementing, evaluating therapy (prescribing, surgery, instructing the patient, compliance of the patient, follow-up, etc).

Rutstein (1976) states the application of a new method of judging the quality of medical care that counts cases of unnecessary disease and disability and needless premature deaths. Medical care is used in its broadest sense. Included are the application of all relevant medical knowledge, the basic and applied research to increase that knowledge and make it more precise, the services of all medical and allied health personnel, institutions and laboratories, the resources of governmental, voluntary, and social agencies, and the supportive responsibilities of the individual himself. Quality is the effect of care on the health of the individual and of the population. Enhancement of the quality of care should be reflected as better health outcome. But quality must be distinguished from the efficiency of medical care. Both are important, but they must not be confused. While quality is the output of the

medical care machine in the form of better health, efficiency has to do with how well the parts of the machine work, how well they work together, and at what cost. In a word, quality is concerned with outcome, and efficiency is related to the process of care.

Roemer and Aguilar (1988) in a study in United Republic of Tanzania describes, that there are four main approaches for gathering information on health care quality:

(a) through normal recording and reporting procedures (including supervisors' reports); (b) through special studies of the health services; (c) means of patient surveys and (d) through household surveys. The four approaches are, of course, not mutually exclusive. If appropriate, two or more of them may be combined. At the community level, and for individual facilities, quality aspects may be included in routine supervision checklists and report forms. The study also reported that lack of medical equipment and drugs was a serious problem, affecting the quality of work. Regarding the condition of the health facilities, the water supply and sanitation were the least satisfactory. The examination of patients was very quick and the quality of the examination in dispensaries was rated as high. Treatment was completely correct for about half the patients, and half the patients received full instructions.

World Health Organization (1988) in its regional health paper states that proper housekeeping procedures in hospitals and health posts are vital because they lessen the number of microorganisms that come into contact with patients and staff, increase safety through prevention of falls, and provide an artistically attractive environment and determine the cleaning method by the type of surface, the amount and kind of soil present, and the purpose of the area. An area without a large number of pathogenic microorganisms can be cleaned with soap and water. Other areas with a large number of pathogenic microorganisms (e. g. isolation areas, toilets, or latrines) need an antiseptic for cleaning. Antiseptics should also be used in areas where mainly susceptible patients are housed (operation theatre, nursery and intensive care units).

Kumar (1989) used indicators for monitoring the level of quality of maternal care where workers were observed with reference to five parameters, (history taking, general physical examination, obstetrics examination, gynecological advice and tetanus toxoid given). Out of 20 observations, if workers performed well in 50 percent

of observations, then a score of one was given and less than fifty percent means a score of zero was given. So for five parameters the maximum score obtained could be five. If the score was three for all aspects collectively, then the quality was taken as acceptable, and not acceptable, if it was less than three.

Locker and Daut (1978) opined that consumers' satisfaction with medical and social services are becoming an important component of evaluative research. Consumer opinion is also coming to find a place in the formulation of health care and social policy. The basis on which consumer's opinions are formulated required detailed investigations so that expressions of satisfaction and dissatisfaction can be interpreted in the context of perceived needs and expectations of care. Thus, evaluating the quality of medical care involves the measurements of its benefits to patients and community at large. The emphasis on consumer's opinion developed as the sociological interest in interpersonal relationships which demonstrated the importance of understanding the patient's point of view. It has been realized that the satisfaction of care is an important influence determining whether a person seeks medical advice, complies with treatment and maintains a continuing relationship with physician. Though interest in the patient's point of view is increasing and consumer satisfaction being adapted as a standard component of evaluative research, there has been little discussion of the methodological and other issues involved in the measurement and use. If consumer satisfaction is to figure as a significant dimension in evaluative research, there is a need to construct an appropriate methodology. This is particularly the case where we wish to compare care environments. In order to obtain an accurate picture of consumer opinion. To that end it is necessary to employ measures that are sensitive and comprehensive. It is also necessary for these measures to be applied to the relevant population.

Donabedian (1980) argues that evaluating quality of care can occur at three points in the delivery of medical services: structure, process and outcome. He defines 'structure' as the tools and resources that providers of care have at their disposal and of the physical and organizational settings in which they work. Process is the set of activities that go on within and between doctors and patients. Here judgment of quality may be made either by direct observation or by reviewing recorded information. Outcome is a change in a patient's current and future health. Quality of

service is described initially in basic terms, but the focus on the health care environment links provision of clinical services with supportive services highlighting the prominence and interdependence of the two.

Fox and Storms (1981) found a weak but a statistically significant relationship between age of the patients and level of satisfaction with older patients being more satisfied with the care they received than their younger counterparts. The association between each of the information factors and satisfaction was considerably stronger, with the strongest correlation between general information and satisfaction. Perceived control was also to be strongly correlated with satisfaction. The information received by surgical patients is an important determinant of point satisfaction, and suggest that more attention should be devoted to this area.

Agarwal and Anand (1985) in their study stated that 'Medical Audit' and the 'Medical Care Evaluation' are synonyms. The authors have strived to convey that medical audit is highly practicable and feasible. To start with internal Medical Audit, by peer-groups, is more likely to be effective than external medical audit. Self-assessment of any degree and of any value is doubtful and therefore evaluation by audit and peer review is more likely to achieve its objectives. The difficulties inherent in medical audit are multitude, but the objective is to evaluate the quality of medical care, to maintain the standards of excellence and if possible, to improve these standards that fall below the accepted levels. It emphasizes the need for continuing education of hospital's clinical staff as well as for systematic logical documentation of the findings within the clinical records, which is very necessary for a valuable exercise in medical audit.

Das and Shahidullah (1988) revealed that 60 percent patients rated doctor's behavior as 'good' and 38 percent had some sorts of disliking for doctor's behavior. The corresponding proportions disclose that the disliking for behavior of nurses and other service providers were 41 percent and 54 percent respectively. The study indicates that non clinical aspects of patient's care need further improvement but at the same time it may be noted that these aspects are not generally as poor as perceived by the people from outside.

Donabedian (1980) evaluated patient satisfaction in a government health care setting where three-fifths of the total patients were male, 35.4% were in the age

range of 15-29 years. About half of the patients reported that nominal physical examinations were done to them', some 3% reported that money was demanded from them for treatment. Meanwhile it was observed that about three-fifth had received full prescribed medicines from the health Centre. The remaining patients either had received part of the prescribed medicine or had received none. Common reasons for not going to the government Health Centers were inadequate attention paid to them by the physicians, inadequate supply of medicines and malpractice of the service providers at the centers in the form of asking money from the patients. The other causes are long waiting time to see the doctor, non-availability of doctors and low-quality treatment.

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areas where mainly susceptible patients are housed (operation theatre, nursery and intensive care units).

Schofield and Girling (1989) state the necessity of examining the quality of the management process. There is an interrelationship between structure, process and outcome. 'Structural features of the settings in which care takes place have a tendency to influence the process of care so that its quality is reduced or enhance. Similarly, changes in the process of care will influence the effect of care. The British Standards Institute recommends the following practices of the term quality: entailing a degree of excellence; reflecting a measurement of a product in terms of departure from an ideal; and demonstrating fitness for purpose, which relates to the ability to meet a given end. Quality becomes more noticeable if we see it as being the extent to which actual performance conforms to requirement.

Fitzpatrick (1991) put forward four distinct functions of patient satisfaction-measurement, understanding patients' experiences of care, promoting cooperation with treatment, identifying problems in health care and evaluation of medical care. Evaluation of health care is regarded as the most important function of patient satisfaction research.

Hossain (1991) stated 39.7% of the patients were partly satisfied and 36.7% were not satisfied with the overall services provided from the outdoor of Dhaka Medical College Hospital. The main factors responsible for disappointment were identified as: waiting time, non availability of medicine and attention of service providers.

Majid (1991) found in his study that hospital wards, premises, latrines and urinals, drains were not clean in most of the health centers at Ishurdi and Chatmohor Thana and about half of the patients visit those health centers. Water supply was present in 85 percent visits at Ishurdi and 81.5 percent times at Chatmohor. Bedpans, urinals and bowls were found 55 percent times unclean at Ishurdi and 46.7 percent at Chatmohor. Thus the service scenario of health centers was more or less poor.

Maher (1991) in her article describes that the quality of medical care generally depends upon three factors, the organization and its staffing, the type and standard of clinical work carried out and the outcome of such service. These three factors are in turn influenced by the needs of the society and the prevailing socio-economic circumstances.

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Kritchevsky and Simmons (1991) describe a growing interest by health care leaders in the continuous quality improvement method of quality management. This method uses measurements of quality 'indicators' to initiate and drive organizational changes in a never-ending cycle of continuous improvement. Many discussions of the continuous quality improvement method have emphasized the organizational and attitudinal changes necessary to fully implement the model while deemphasizing the uses of measures of quality to guide improvement. They emphasize the concepts behind the measurement of quality that underlie the continuous quality improvement model and give examples of how these concepts can be immediately applied to guide improvement in the quality of physician care. Continuous quality improvement can be organized around the following four tasks once the attributes used to define the quality of care have been selected: (1) separating externally caused problems from systemic problems; (2) monitoring the system to make sure no new extra systemic problems occur; (3) studying the system to identify how problems arise within the system; and (4) evaluating the efficacy of changes to the system. The first two tasks involve maintaining the system of care actually in place. The latter two involve changing the system to improve the quality of care.

Susan (1991) in their study developed three risk-adjusted measures of hospital quality; the risk-adjusted mortality index (RAMI), the risk-adjusted readmissions index (RARI) and the risk-adjusted complication index (RACI). Using existing data sources they described the construction and validation of each of these indexes. After that they tested the relationship among the three indexes using a sample of 300 hospitals in USA. For the risk-adjusted readmission index (RARI), the dependent variable was whether an unanticipated readmission to the same hospital occurred within 30 days after discharge. Risk factors were established empirically within each disease category for each index. A multiple regression analysis was used to test for

bias, using hospital characteristics as the independent variables. Study findings suggested that hospitals that rank well in terms of mortality rates do not necessarily do well in the other measures, and may have excessive readmissions or complications.

Faruq (1993) in his study found that maximum patients were dissatisfied with the quality of major food items supplied by the hospital. Only the quantity of rice and vegetable was considered as adequate by majority of cabin patients. He conducted the study at Dhaka Medical College Hospital and Infectious Disease Hospital to assess the hospital diet in terms of nutrition content and patient acceptance. The study was aimed to find out the view of the patients about the quality and quantity of food item served in the hospital and the food serving process. It was found that the number of patients accepting the hospital diet in full was not satisfactory in both of the hospitals.

Das and Rahman (1993) in their study used eight indicators to assess quality of care. These were, physical examination by doctor, advice for laboratory investigation, prescribed drugs to be purchased from outside, advice on diet, given health education, referral to higher facilities, advised to follow up. They found that 39 percent were physically examined, 8.7 percent were advised for investigation. About 93 percent reported that they had received some drugs from the health facilities, about 12 percent were given health education and 3.6 percent were referred, referral of patient was a rare event. For follow up, 26.4 percent were asked to visit again. At present there is no set of indicators of the quality of patient care including clinical and non-clinical tasks on the part of the service provider. As a result, they are not adequately oriented to the concept connotation and their behavioral aspects concerning essential elements of patient care. The existing reporting and supervisory systems are not also designed to make quality assessment of patient, resulting in inadequate accountability on the part of service providers. It is possible to improve the quality of patient care provided that a number of essential elements of care are integrated with the standard. In the absence of standard quality, the people will continue to have their own subjective health facilities. It is high time now to take steps for initiating quality assurance measures in health facilities throughout the country.

Islam (1993) carried out a study to estimate bed occupancy rate, average length of stay, outcome of treatment and illness summary and to identify the factors responsible for bed utilization. The bed occupancy rate was 66 percent and average duration of stay was 4.4 days. Among the admitted patients 91% percent were cured and improved. According to doctors, laboratory facilities, food and medicine supply were inadequate.

Hossain (1993) in his study found that two-thirds of the patients in TMC (full meaning needed) were illiterate. By occupation, about half of the patients were farmers. The overall occupancy rate was 54.8 percent and average duration of hospital stay of patients was 3.5 days. Physical check-up and investigations were accomplished in about 90 percent and 50 percent cases respectively. One-fifth of the patients opined about poor supply of drugs. Quality of nursing service was very poor. About half of the patients were not advised to perform any investigations for diagnosis of their diseases. About three-fifths of the patients were suggested to perform all investigations from government hospitals. Half of the patients were not visited everyday by the doctor. Approximately one-fifth patients received all drugs from the Thana Health Complex (THC). About four-fifths of the patients purchased drugs from private drug shops outside the hospital. Almost all patients told that bathrooms were cleaned daily. But about half of the patients reported that latrines were not cleaned daily. Three fifth of the patients opined that the quality of diet was poor and one-fifth opined that diet was not of any quality.

Carol and David (1995) conducted a study, the association between the quality of inpatient care and early readmission. Quality of care during the index stay was assessed by chart review using disease-specific explicit criteria for the process of inpatient care, which were developed by panels composed of expert physicians. Adherence scores were calculated for the admission workup, evaluation and treatment and readiness for discharge. After adjustment was made for demographic characteristics, severity of illness, and need for care, adherence scores correlated with early unplanned readmission ($P > 0.05$). For patients with diabetes and heart failure, decreased readiness-for discharge adherence scores correlated with increased risk for readmission ($P = 0.001$ and $P = 0.016$, respectively). Inpatients with obstructive lung disease, decreased admission-workup scores correlated with

increased risk for readmission ($P = 0.13$). 1 of 7 readmissions of patients with diabetes, 1 of 5 readmissions of patients with heart failure, and 1 of 12 readmissions of patients with obstructive lung disease were attributable to inferior care. Lower quality of inpatient care raises the risk for unplanned early readmission of patients with heart failure, diabetes, or obstructive lung disease. Under certain circumstances, readmission is associated with remediable shortages in the process of inpatient care.

Das and Rahman (1993) define 'Quality' as grade of goodness, merit or excellence of a thing or activity, accomplishment or attainment. Quality as a characteristic of health care may be defined at two different levels. At the general level, the quality pertains to the health care system as a whole. In this context, it implicates resources, activities of management, outcome of health care, and specifying the merit or excellence of the system in all its components. At a more restricted level, the quality denotes the characteristics of health care resources and activities. In regard to health care resources, quality may be defined as the suitability for providing the planned services in a reliable manner. It is indicated by training, skills, knowledge, attitude, and behavior of the personnel, by the degree of cleanliness and safety of the health care facilities, and adequacy of the equipment and supplies. The quality of medical care may refer to patient provider interactions, physical examination, investigation, rational prescribing, treatment outcome, etc.

Roy (1994) in his study tried to find out the level of expectation of the patients with regard to their doctors' attention to their complaints, physical investigation, pathological examination, behavior of doctor, quality of food, and supply of medicine and overall satisfaction level on services provided from the hospital. He found that four-fifths of the respondents were satisfied with the overall service provided from the indoor department of Thana Health Complex (THC). The major factors for dissatisfaction were identified as non-availability of medicine, rough behavior of health personnel, inferior quality of diet, non-availability of staff during need, cleanliness of indoor departments and linen etc.

Rahman (1994) in his patient satisfaction study reported that about three-fourths of the total patients were satisfied with cleanliness of the wards, premises and toilets of private clinics. Majority of the patients (84%) would recommend their sick friends and

relatives to admit in private hospitals. There was relationship between income of the patient and recommendation to clinics with higher income group having fascination for private clinics. Behavior of doctors and nurses in private hospitals was good.

Haque (1994) stated that the services rendered by the OPD are not sufficient for a sick patient, the need of inpatient services raised. Inpatient services provide twenty-four(24) hours patients monitoring and supervision, medical, surgical, diagnostic, therapeutic and resuscitative services where needed along with dietary and hotel type services. The smallest unit of inpatients care is the hospital bed. For convenience these are grouped together in units of usually 20 to 30 beds, whether in single, double or multiple rooms, these groups of beds are known as wards or nursing units that is the module of inpatient care. Inpatient services in hospital can be divided into following groups: (1) general care, and (2) specialized care. The inpatient services include in number of activities in providing the care to the sick and the injured. The main functions of inpatients departments are accommodation for the patients, diagnosis and treatment of the patients and the nursing care of the patients. Begum (1994) found that the diet provided to different types of patients were about 50 percent of their calorie need. The patient consumption of food supplied by the hospital was very low. Except BIRDEM, majority of the patients in other hospitals were not satisfied with different types of food supplied by the hospitals. Dissatisfaction was found more in Dhaka Medical College Hospital (64.5%) both in quality and in quantity. They stated that in most of the hospitals there is no trained dietician, menu planning was not as per prerequisite of different types of unhealthy patients, budget per patient per day was negligible and as a result food was not served even with the amount mentioned in diet. Ferdous (1996) observed that the food was not palatable to all the respondents in some selected hospitals and majority of the respondents (71% percent) opined that food had unpleasant odor.

Weingarten (1995) conducted a study on patients' satisfaction and adherence to preventive care practice guidelines in Cedars-Signal Medical Center, Los Angeles. They studied the association between patient satisfaction and the quality of medicalcare received by patients in physician offices. They found significant association between patient satisfaction and the performance of some but not all preventive care services. Those who received health education were more satisfied

with their medical care than those patients who did not.

Faruq (1995) found that 70% of the patients were literate and about 60% were satisfied with the overall services provided at outdoor. The major causes of dissatisfaction were some sorts of disliking for doctors behavior (about 82% percent), carelessness of other staffs (about 37 percent), and less availability of medicines (8 percent). The study indicates that clinical as well as non-clinical aspects of patient care were more or less satisfactory but needed further improvement.

Davies and Crombie (1995) stated that everyone wants information on clinical outcomes. These measures have a spontaneous appeal- high quality care should be reflected by good outcomes. Therefore, poorer outcomes should indicate insufficiencies in care, including missed opportunities or wasted resources. The hope is that data on outcomes will provide a barometer for health care, indicating effectiveness and efficiency of service delivery. Many purchasers are pushing to include outcomes criteria in their contracts as a means of assessing effectiveness. In clinical audit, measurement of outcome is generally considered superior to audits that simply assess the process of care.

Inayat (1995) in his article described that the quality in medical profession is similarly essential for achieving highest possible care at lowest possible cost. Quality of medical care must be as old as medicine itself. Among the pioneers of methodical assessment was Florence Nightingale. Quality of care is not the same as clinical efficiency. Medical process incorporates a set of both client and provider behaviors with complex interaction between them which follows use of services and health and welfare of the client. Thus, assessment of 'Quality' can be defined as a judgment concerning the process of care, based on the extent to which that care contributes to valued outcome. Donabedian had provided the components of quality of care, which have been stated earlier in this chapter. Lately scope of 'Quality' has been broadened to 'Quality assurance' and 'medical audit' implying not only assessment of quality but also identification of reasons for low quality and interventions so as to improve it. Quality has also been assessed from another viewpoint by identifying its dimensions in terms of effectiveness, equity, efficiency and humanity.

Carol and David (1995) conducted a study, the association between the quality of inpatient care and early readmission. Quality of care during the index stay was

assessed by chart review using disease-specific explicit criteria for the process of inpatient care, which were developed by panels composed of expert physicians. Adherence scores were calculated for the admission workup, evaluation and treatment and readiness for discharge. After adjustment was made for demographic characteristics, severity of illness, and need for care, adherence scores correlated with early unplanned readmission ($P > 0.05$). For patients with diabetes and heart failure, decreased readiness-for discharge adherence scores correlated with increased risk for readmission ($P = 0.001$ and $P = 0.016$, respectively). Inpatients with obstructive lung disease, decreased admission-workup scores correlated with increased risk for readmission ($P = 0.13$). 1 of 7 readmissions of patients with diabetes, 1 of 5 readmissions of patients with heart failure, and 1 of 12 readmissions of patients with obstructive lung disease were attributable to inferior care. Lower quality of inpatient care raises the risk for unplanned early readmission of patients with heart failure, diabetes, or obstructive lung disease. Under certain circumstances, readmission is associated with remediable shortages in the process of inpatient care.

Uddin (1996) in his study found that waiting time for the patients at out-patient was less than an hour in about 90% percent cases and 93% percent patients received treatment within 20 minutes of admission. Almost all patients opined the behavior of the service providers was good. Cleanliness in case of wards, premises, toilets, and operation theatre was good and case history writing was found complete, but the quality of record keeping was average. About 60% percent emergency equipment was available in both the wards but 30% percent equipment was lacking in medical wards .

Robert and Elizabeth (1996) in their article describes there are five methods by which quality can be assessed on the basis of process data, outcome data, or both. The first three methods are implicit – that is, there are no prior standards or agreements about what reveals good or poor quality with each of these methods, a health care professional (usually a doctor) reviews a data source (usually a medical record, after care has been provided) and answers one of the following questions: was the process of care adequate (first method)? Could better care have improved the outcome (secondary method)? Considering both the processes and outcome of

care, was the overall quality of care acceptable (third method)? The fourth method evaluates the provision of care with the use of explicit process criteria. The fifth method uses explicit priority criteria to determine whether the observed results of care are consistent with the outcome predicted by a model that has been validated on the basis of scientific evidence and clinical judgment. The explicit expectations are then compared with the actual outcomes.

Khaleeda (1996) in her study reported that a significant portion of respondents stated that doctor's service, nursing service, staff service and laboratory service were inappreciable. Dissatisfaction was more in middle- and upper-income group. Regarding cleanliness, two-thirds respondents stated that bed-sheets and pillow covers were not changed in a week, toilets were not cleaned and water supply was not continuous. More than half of the respondents were dissatisfied with overall services.

Rahman (1996) in his study found that half of the respondents were illiterate and in the middle-income group. Four-fifths respondents opined that service provided by doctors and nurses was good. Majority of the respondents (three-fifths) received medicine partially from the hospital. Half of the respondents opined that diet supplied to them was average. Bed occupancy rate was around 123 percent and average duration of stay was 3.16 days. Most of the patients opined that doctor's service and nurse's service were good, but cleanliness was average. Out of them two-thirds of the respondents performed investigations from the hospital.

Chen and associates (1996) opined that patient satisfaction surveys often report remarkably high levels of contentment or satisfaction with health services. It may be a valid reflection of patient views for some components of care and not simply an artifact. It has long been acknowledged that wording and presentation of questions may influence response.

Fitzpatric (1996) noted that many patients appear to have more confidence in commenting on convenience, cost, and doctors and nurses' personal qualities than in expressing dissatisfaction with medical.

Sharif (1996) observed that identification data or particulars of patient were recorded in most of the (four-fifths) cases. Diagnosis at the time of admission was not recorded in all the cases. Chief complain was recorded and investigation was

advised in almost all the cases. Diet orders were not given in two-thirds of the total cases. Description of treatment was written in a small number of (one- sixth) cases. Outcome of treatment was noted in almost all the cases.

Islam (1997) in his study found that cleanliness of surgical ward, medical ward and labor ward, linen, urinals and bowl, wet moping, sanitary condition of the concerned medical college hospital was unsatisfactory to most of the respondents.

Rashid (1997) in his study showed that treatment of two-thirds respondents was started within a few minutes. More than half of the respondents opined that doctor's visit and follow-up visit started within 12-34 hours. About seven-tenths of the respondents stated that there was no daily mopping. All the respondents stated that nurses administered drugs and remade patients' bed once in the morning.

Rahman (1997) in his study found that investigation was advised to half of the cases. Almost all the respondents had to buy their essential medicine from outside the hospital. The average length of stay was about 3 days and bed occupancy rate was around 119 percent. The overall record keeping was not satisfactory. About two-fifths respondents were satisfied with overall services of the hospital.

Curry and associates (1997) reviewed Pickup Quality Project within the Scottish Health Service. The aim of the review was to provide answers to a number of important questions which examined the perceptions of staff who took part in the Quality-of-Service initiative, identified parts of the process which were in need of substantial revision, and reported on the reactions of participants to the overall process. It was evident that good quality of service training can be delivered, but only if it is clearly and appropriately tailored to the audience. The financial limitations heightened the general business sensitivity and showed that carrying through quality-of-service improvements involved the demonstration of commitment and the provision of resources. Quality of service is an important field of study and especially in the health care environment were the efficient and effective use of resources in critical, and the managerial, clinical and administrative aspects of the service need to be brought closer together. The advent of the Patient's Charter (NHS, 1991) and devolved management among other issues have concentrated the mind on potential consumer / provider partnerships in health care (patients / their families / clinicians), in parallel with education (pupils / parents / teachers) in response to the parents'

charters.

In the study, carried out by the integrated community Family-Health Development Program (ICFHDP, Bogra), the National Institute for Population Research and Training (NIPORT), and the district level authorities of the Ministry of Health and Family Welfare (MOHFW) (1977), attempts were made to assess the expectations and the level of satisfaction of users attending the Health and Family Welfare Centers (HFWC), Rural Dispensaries (RD), and Satellite Clinics (SC) upon the quality of services delivered to them. They found that 75 percent of clients expressed they would be satisfied if they do not have to wait more than 11 minutes. Clients also said that the best time for coming to the facilities would be before noon. With reference to the client-provider interaction process, most clients expected good behavior from providers. Satisfaction with providers' behavior was found high (95.2%), and the overall level of satisfaction was found 88.2 percent. However, a significant level of dissatisfaction was found in relation to waiting time (28.2%), and with clinic hours (34.2%). It was found that satisfaction with provider's behavior was a powerful predictor of the overall level of satisfaction. Likewise, information on clinic hours, waiting time and consultation time, as well as the behavior of the different variables in presence of certain characteristics of clients, or services will help managers and decision makers for a more comprehensive implementation strategy.

Islam (1997) in an attempt to find the level of patient satisfaction found that 84 percent respondents were pleased with overall emergency services in ward and 64 percent satisfied with the admission system of the hospital, 66 percent satisfied with doctor's service, and 35 percent opined that nurses were polite and compassionate. Contrarily, 61 percent stated the privacy of labor room was not maintained due to male consultants and male doctors.

Islam (1998) found that three-fourths of the patients attended/admitted at BIRDEM Hospital were satisfied with admission system of this hospital. Majority expressed that the doctors visited the wards once per day, but three-fifths wanted the authority to increase the number of doctors' visits in the indoor departments. Majority (three-fifths) stated that the behavior of doctors and nurses were good. All respondents were satisfied with the availability of aya and sweeper and cleanliness of wards and latrines, supplied diet, treatment facilities were appreciable. But almost all the

respondents were dissatisfied with hospital cost and about one-fifth respondents were dissatisfied with overloading of visitors.

Benjamin (1999) stated that although measures of consumer satisfaction are increasingly used to supplement administrative measures in assessing quality of care, little is known about the association between these two types of indicators. This study examined the association between these measures both at an individual and a hospital level. Regression analysis was used to determine the association between satisfaction and administrative measures of quality for subsequent outpatient follow-up. At the patient level, satisfaction with several aspects of service delivery was associated with fewer readmissions and fewer days readmitted. Better alliance with inpatient staff was associated with higher administrative measures of rate of follow-up, promptness of follow-up, and continuity of outpatient care, as well as with longer stay, for the initial hospitalization. At the hospital level, only one association between satisfaction and administrative measures was statistically significant. Hospitals where patients expressed greater satisfaction with their alliance with outpatient staff had higher scores on administrative measures of promptness and continuity of follow-up.

Karim (1999) in his study of Thana health complexes found that majority of the patients were satisfied with doctor's service, nurse's service and other services except laboratory services including X-ray facilities (50 percent opined poor). Housekeeping was good in two Thana health complexes but it was bad in other selected health complexes.

Hannan and colleagues (2000) studied the management efficiency of Government run TB treatment centers. They found that all of the attended patients received appropriate laboratory investigations and medicines from the centers. However, the selected centers lacked X-ray facility. Mean waiting time to meet a doctor was nearly one hour. Most of the patients were satisfied with the service given. Majority (72.6%) of the patients was fully satisfied and the remaining patients were satisfied to an average level. The level of dissatisfaction increases as with increasing age and income.

Krupat and associates (2000) states that greater satisfaction was significantly associated with greater age and less education, and somewhat significantly

associated with being married and having higher social status (scored as a composite variable) emphasizing occupational status. The average magnitudes of relations were very small with age being strongly correlated to satisfaction. No overall relationship was found for ethnicity, sex, income or family size. For all socio-demographic variables, the distribution of correlations was significantly heterogeneous, and statistical contrast revealed the operation of several moderating variables.

Andaleeb (2001) describes patients' perceptions about health services which seem to have been largely ignored by health care providers in developing countries. This study examines the associated factors of patient satisfaction in the context of Bangladesh. Evaluations were obtained from patients on several dimensions of perceived service quality including responsiveness, assurance, communication, discipline, and baksheesh. Such perceptions, especially about service quality, might shape confidence and subsequent behaviors with regard to choice and usage of the available health care facilities is reflected in the fact that many patients avoid the system or avail it only as a measure of last resort. Patients' voice must begin to play a greater role in the design of health care service delivery processes in the developing countries.

Tengilimoglu and associates (2001) stated that direct measurement of patient satisfaction is a relatively new phenomenon for the US. A system was designed similar to those available in the US and was applied during an exit interview. Three areas of analysis were identified: accessibility and availability of services, perceived quality of patient care and organizational and administrative issues. Relationships and percentages within and among several variables are reported. Most individuals were satisfied with direct patient care, although in some areas this varied significantly and was based on the education level of the respondent. In addition, many consumers reported dissatisfaction with organizational and administrative support services. They recommend that hospitals in Turkey adapt routine policies similar to those in the US for conducting these types of evaluations. Measurement of patient satisfaction is an important outcome variable while evaluating overall hospital viability in the current healthcare delivery system. The results of patient satisfaction surveys and instruments are often used in many areas of the administrative and

clinical process, such as for supplementing quality assurance or quality evaluations, as well as for the design format for health and administrative services. Patient satisfaction surveys have evolved into powerful management, planning and marketing tools within the US healthcare sector.

Mallik (2002) in his study of Armed Forces Hospital found no statistically significant difference among the three groups of patients in overall quality of care. It is widely believed that hospital readmission has a relationship with the substandard care in previous stay. But findings of this study were not consistent with the findings of other studies. So, it can be concluded that readmission in an armed forces hospital is probably related with the different characteristics of the study of population, disposal procedure of disease condition and the attitude of the physicians towards admission process.

Siddique (2002) in his comparative study between BIRDEM (Private hospital) and Dhaka Medical College Hospital (DMCH) (Public hospital) observed that all patients (about 93%) of BIRDEM hospital and 80 percent of DMCH were satisfied. The study considered cost incurred and overall care as determinants of patient satisfaction and found that satisfaction with information receiving, family education and information, actual treatment, physical care, nurses' quality, hospital discipline and admission procedure were predictors of satisfaction. The difference in the level of patients' satisfaction in the two hospitals was statistically significant.

Haque (2002) in a study conducted in tertiary level TB hospital in Dhaka took three-fourth male and one-fourth female respondents aged 15-44 years. Majority of the respondents poor (monthly-family income of Taka 3000). Quality of care was assessed in terms of 8 indicators e.g. nursing care, services by the staff, general medical care, investigation facilities, drug availability, food services, water supply, and state of indoor indicators e.g. nursing care, services by the staff, general medical care, investigation facilities, drug availability, food services, water supply, and state of indoor environment. Majority of the respondents (four-fifth) reported that the nurses did not distribute the medicines according to dose schedule and their temperature was not recorded at all. They also complained that the doctors did not perform daily follow-up visits. But majority of the respondents were satisfied with the behavior of the doctors and nurses. Almost all respondents had some of the

investigations from the hospital. Quality of the supplied diet was satisfactory and good according to three-fourths of the total respondents. Almost all respondents opined that sweeping and mopping of the floor of the wards was done irregularly and staff did not clean the bedside bowl at all. The condition of the bathrooms and latrines was not good and water supply was not on full time basis.

Rahman (2002) in an attempt to assess the quality of care in in-patient and out-patient departments of rural and urban government hospitals in Bangladesh stated that the quality of health care is the consequence of strong link between serviceproviders and user of the services. Perceived quality is one of the principal determinants of utilization and non-utilization of health services, a major issue in developing countries. He found that age, waiting time, time spent for patient examination, place of treatment, income, years of schooling and male sex appeared to be independent predictors of patient satisfaction. Age, waiting time and years of schooling were negatively related to the level of satisfaction indicating younger patients, less waiting time and patients with less education are more satisfied, whereas time spent for examination. In the urban hospitals males were more satisfied with services than the females. The study recommends that both short and long-term policy action should be adopted for quality assurance of the existing health care facilities in Bangladesh. Fishbein and Ajzen distinguished attitudes from perception and stated that satisfaction is the perceived difference between what an individual desires and what occurs. It is the difference between rewards desired and those received. Satisfaction is perceived equally of balance of inputs.

Demir and Celik (2002) conducted a study among patients of a military teaching hospital in Turkey, published online (March 2002). A patient satisfaction questionnaire using a 4-point Likert scale was mailed to 500 patients after discharge and 316 questionnaires were returned. The findings indicate that the satisfaction with physician, nursing, physical plant, and food services was the main determinant of overall satisfaction with the hospital. The type of clinic in which the patients stayed also was an important determinant. The effect of patients' demographic characteristics on overall satisfaction with the hospital was also examined, and only lower education level was found as a statistically significant determinant.

Rudzik (2003) states that surveys of patient satisfaction are widely used for identifying priorities and problems in health care reforms. They examined satisfaction and confidence of patients in public health care (PHC) in Trinidad and Tobago. Level of patient satisfaction was high but not constant. Results of interviews showed that patients with a higher monthly income and patients who most recently used private medical care had lower levels of satisfaction with health services. Employment had an effect on satisfaction, significant among patients who had recently had access to private medical care. Patients using PHC preferred private care to public. Confidence in public care decreased with increasing complexity of the medical condition. These preliminary results support continued efforts in health-sector reforms and call for the enhancement of data on satisfaction through more comprehensive qualitative data-collection methods.

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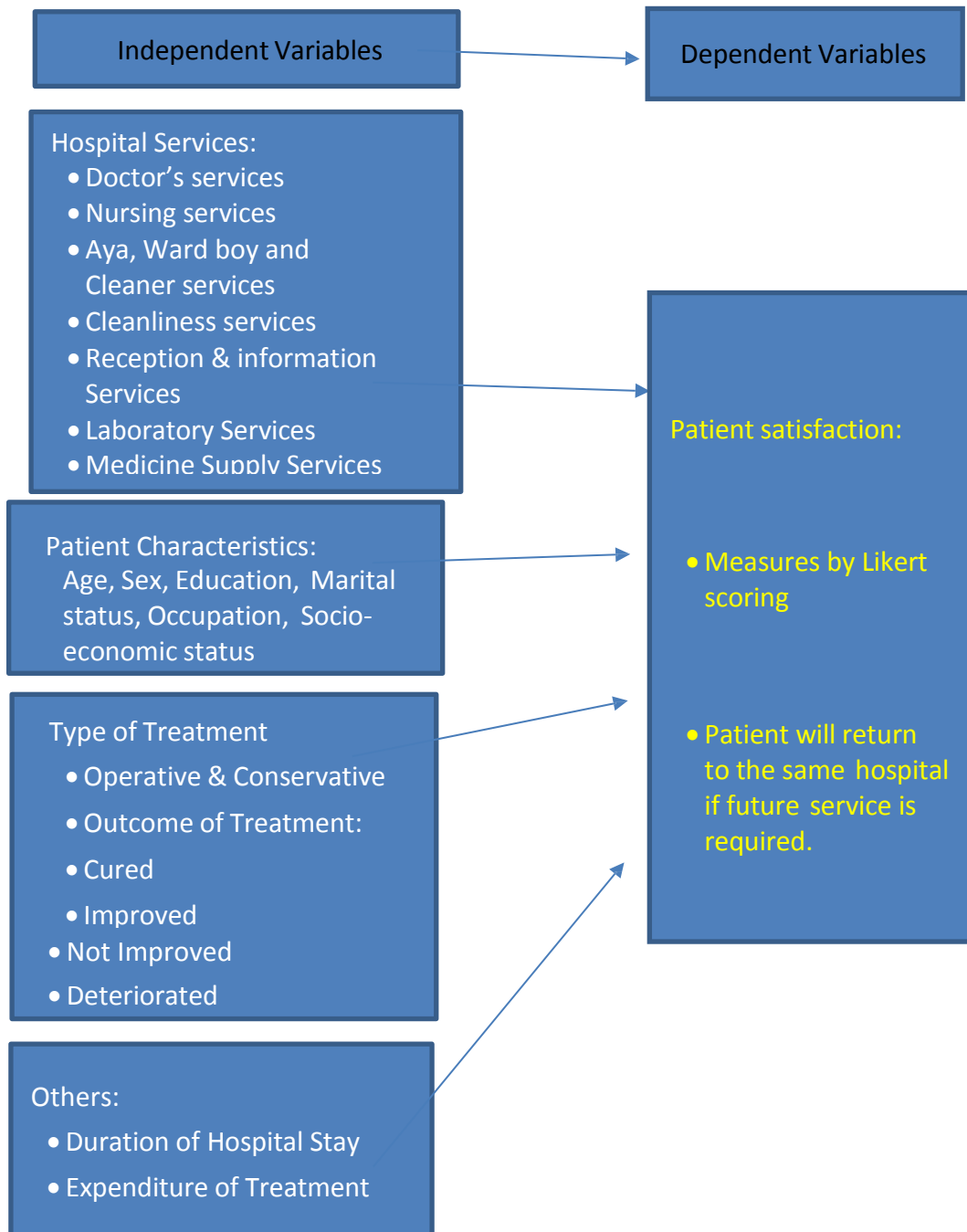
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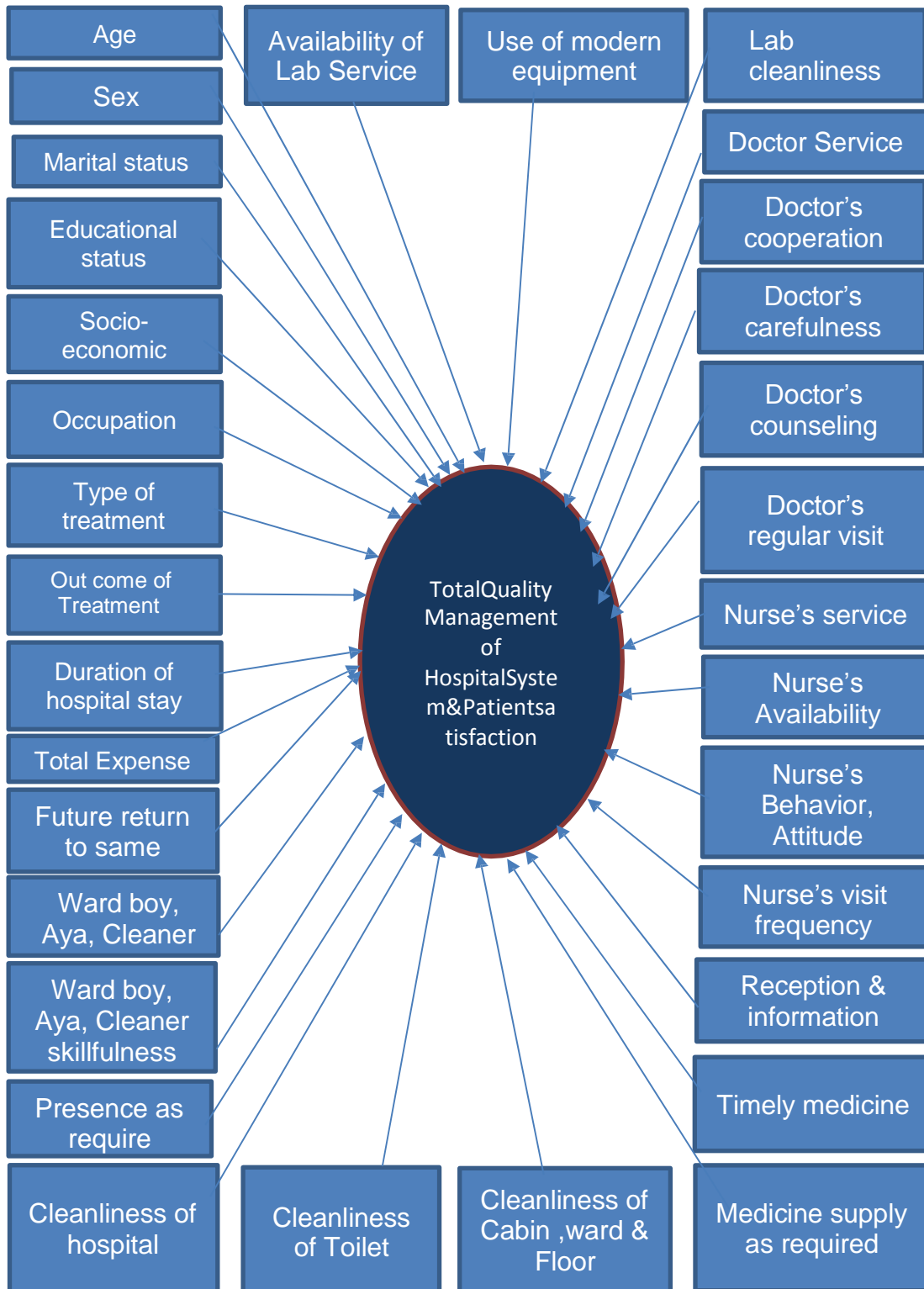
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CHAPTER 3: DATA AND METHODOLOGY

Conceptual Framework:



Conceptual Framework



Study design:

Across section al study designed followed consisted of data collection by questionnaire and presentation of data with statistical analysis. It is an empirical study to measure patient's satisfaction both in public and private hospitals in Bangladesh.

Study population & Area:

The focus on hospitals in Chattogram City was deemed appropriate for several reasons. Chattogram has large number of hospitals of varying quality that attend adverse set of patient needs. Two separate lists of public and private hospitals in Chattogram were obtained from the Ministry of Health and Family Welfare. From the former list, Chittagong Medical College and Andarkilla 250 Beded General Hospital were chosen purposively as the set two hospitals have reputation to handle patients from all classes and with various health problems. Chittagong Medical College Hospital is the top and first public medical college hospital of Chattogram, Bangladesh. Andarkilla 250 bedded general hospital is also an oldest hospital in Chattogram. These two are the leading hospitals with highest patient turn over in Chattogram. Both the hospitals have long experiences in patient management. The other public hospital selected is Bangladesh Institute of Tropical and infectious Diseases Hospital that represents one of the largest hospitals outside Chittagong having huge patient load.

In addition, three hospitals were also purposively chosen from the list of private hospitals. These include Chattogram Ma o Shisu Hospital, Agrabad, Chattogram International Medical College hospital and Bangabandhu Medical College & Hospital. Chattogram Ma-o-Shishu General Hospital, Agrabad is one of the pinnacle private medical college hospitals in Chattogram providing services at an affordable cost. Chattogram International Medical College Hospital is also an old hospital with moderate cost. Both are general teaching as well as referral hospitals, with sophisticated technology and skilled manpower. Bangladesh institute of tropical and infectious diseases (BITID) is also serving the different classes

of patients for a fairly long time. These three hospitals are representatives of private hospitals of Chittagong as well as the country, because lower, middle and rich people can consume the services of these hospitals. There are few other highly expensive hospitals in the country but they are not accessible to poor and lower middle-class people, so they cannot represent general population. Hospitals at district or upazilla level were not included because they are representatives of a small area, small number of beds, not homogeneous, unavailability of records and poor turnover. Besides, all the large private hospitals with minimum age of five years are in Chattogram. As such all the sample private hospitals were selected from Chattogram. Moreover, all the selected private and first two public hospitals have good road access, which was convenient for the researcher to reach and work from his place of residence.

Study period:

The study is mainly based on primary data collected through face-to-face interviews with randomly selected patients from the sample hospitals during the period Jan 2025 to July 2025.

Hypothesis:

H0: There is no significant difference of patient satisfaction between private and public hospitals in Bangladesh with respect to doctor's service, nurse's service, aya / ward boy and cleaner's service, cleanliness, medicine supply, laboratory service, reception and information service.

Questionnaire and Scale Used:

A preliminary questionnaire was first developed in English using Likert scale, then translated into Bengali. The questionnaire was pre-tested to arrive at appropriate wording, format, length and sequencing of the questions. Pre-test feedback was used to refine the questionnaire until it was ready for data collection.

The level of satisfaction of the respondents was measure do na1-5 Likert scale, where numeral 1 meant for 'not at all satisfactory' and numeral 5 for 'excellent',

'some what satisfactory', 2, 'more or less satisfactory', 3, and ' appreciable', 4 in between them. Level of satisfaction was measure don all the discrete services (mentioned under the key variables section) received by the respondents. This for math as been recommended for health care surveys (El beck 1987 and Steiber 1989). Multiple items were used to establish appropriate measurement properties (reliability and validity) of the selected constructs.

Sample size Calculation:

Sample size of the study will calculate using the following formula at be enrolled in the study: $n = z^2 pq / d^2$, Chi-square test.

Inclusion Criteria:

The respondents with given consent who will willingly join or participate in the study. Both male and female person will be selected as participants.

Exclusion Criteria:

Data collection

Tools:

Sampling Technique:

Randomized, sequential, purposive and plenitude sampling methods will be followed.

Data Collection Technique:

By following face to face interview of the participants.

Data Analysis & Management Plan:

After the completion of data processing, the researcher has turned his attention to analyze both qualitative and quantitative data. The data were analyzed by using Statistical Package for Social Science Version 20(SPSS). In course of descriptive analysis, frequency, mean, standard deviation (SD), and standard error

of mean (SEM) have been adopted. On the other hand, continuous variables were compared using independent sample t test and categorical data were compared by Chi- square test. Correlation analysis was done to see the positive or negative effect of the variables. Factors associated with patient satisfaction (future return to the same hospital) were analyzed by binary logistic regression analysis, and one way ANOVA was done for comparing more than two groups. Hypothesis was justified by independent sample t test for scoring of patient's satisfaction. Analyzed data were presented in the form of tables and graphs and were duly interpreted. Level of significance was set at 5% and $p < 0.05$ was considered statistically significant.

Ethical Consideration:

For conducting the study, Ethical approval will be obtained from ethical board of Selinus University. The personal identification, information of the subjects involved in the research will be replaced by codes in the protected archived computer data files. The paper forms with the personal identification information will be stored in high security procedures. Data files for statistical analysis will be prepared to ensure the confidentiality of any information about the study participants and will not include any personal identification.

Quality Control & Quality assurance: Following measures were taken for quality control & quality assurance:

- ➡ Regular assistance and guidance from the supervisor will be taken for conducting interview.
- ➡ Data collection and analysis will be performed by the researcher himself.
- ➡ Report will be made with the respondents before data collection.
- ➡ Data will be checked and rechecked for reliability.
- ➡ A semi-structured questionnaire will be used.
- ➡ Questionnaire will be explained in local languages for better understanding.

Expected Outcome:

Sufficient knowledge, awareness and Practice will be gained regarding different selective Public & Private Hospital among the respondents. Their health behavior will be improved and updated in their hospital. In practice nothing will improve the quality- of-service delivery until and unless all service providers are passionately committed to patient satisfaction and the policy planners are giving strenuous efforts to the whole issue and both the government and private sectors are committed to provide quality services to the people at affordable cost. A very good impact of health education will be created on the target community.

**FLOWCHART OF CROSS SECTIONAL STUDY
(Questionnaire Based)**

Selection of different places for the data collection



Data collection from the respondents by following questionnaire



Compilation of data in record book and data entry to spreadsheet



Processing of the data using software for statistical analysis



Presentation of data by charts or graphs and tables



Making conversations with the supervisor regarding the findings



Finally, Thesis/ Dissertation submission

Chapter 4 Contents and Results

Health is a basic prerequisite for improving the quality of life, which has an impact on socio-economic development of the country. The health care system in Bangladesh is a combination of public and private enterprises. Poor and deficient health services are acting as an impediment to overall progress of this country. Health care service delivery, like any other services, depends on the cooperation between two parties that is to say the provider and the consumer of the service. 'Patient satisfaction' with health care is seen as a dimension of the quality of care. Measuring patient satisfaction requires detailed investigations so that expressions of satisfaction and dissatisfaction can be interpreted in the context of perceived needs and expectations of care. There are several studies on patient satisfaction in Bangladesh, which discover that a substantial number of patients are not satisfied with the services. With this background research questions, hypothesis and objectives have been articulated for this research. This is a comparative study between private and public sector. This study would help future researchers in this field to formulate their research problems as well as the decision makers to understand the demand and need of both inpatients and outpatients of the hospitals in Bangladesh.

Chapter 5: Discussion

- Interpretation of Results: Analyze the findings in-depth. Compare my results to the existing literature reviewed in Chapter 2. Discuss why certain TQM practices are more effective in one setting versus the other and how these practices influence patient satisfaction.
- Implications for Hospital Management: Based on my findings, provide recommendations for improving TQM practices in both selective private and public hospitals in Chattogram City.
- Comparison of Selective Public and Private Hospitals: Discuss the main differences, I observed between selective public and private hospitals regarding TQM implementation and patient satisfaction.

Chapter 6: Conclusions

- Summary of Key Findings: Have to recap the main findings from my study, including the relationship between TQM practices and patient satisfaction in Selective private and public hospitals.
- Conclusions: Have to draw conclusions based on my research questions and objectives.
- In the present study, it is seen that majority of private respondents evaluated the services given at the private hospitals as 'excellent' or 'appreciable', while it is less appreciable in public hospitals. In case of segmental services like doctor's service, nurse's services, provision for medicine supply, services given at the reception, Aya/ward boy and cleaner's service, laboratory service and maintenance of cleanliness, around one fourth of the public respondents held the view that they were 'not at all satisfactory'. The doctor service is the significant predictor of future return to the same hospital. The findings generated thus may help the planners and policy-makers to formulate a right strategy to improve the present situation of public hospital management.
- Most of the people of Bangladesh are of poor socio-economic status and they have to avail the services from the public sector. But it is frustrating for the health system of the country that the evaluation of services by significant number of patients is not at all satisfactory. Till now public sector is the only active system at the doorstep of poor and middle-class population. Most of the people cannot afford the cost of private health services. So, it is urgently needed to address the loopholes of the public health sector and accountability of the service providers of this sector must be ensured.

Appendices A: Informed Consent

I, Mr./Mrs. ----- has read all the statements in the consent form and I do hereby agree to voluntarily participate as a subject in the study of ““Total Quality Management of Hospital System and Patient Satisfaction in Bangladesh: A Comparative Study between Selective Private and Public Hospital in Chattogram City””.

I have clear idea of this research including its purpose, duration and the procedures to be followed. I have understood that all information will be kept confidential. My name will not be published in the study report and I will not be entertained with any financial benefits or incentives.

I have been given opportunity to ask questions concerning research procedures and for further questions.

I may contact the research workers. I have also been given information on the risk and discomforts for participating in this research.

I understood that I have the right to leave or cancel my consent and withdrawal myself from the study at any time for any reason without penalty. I have been informed that I shall be given a copy of the signed consent to keep.

I, the undersigned, certify that I have signed this document willingly to participate in the said research work myself or in presence of the following witness.

Participant’s signature

Name:

Date:

Witness’s signature

Name:

Date:

Investigator’s

signature Name:

Date:

Appendices B: Questionnaire

Dear participant,

I'm Ranjan Prashad Das Gupta, research student of the Department of Business & Media at the Selinus University of Italy.

I have to conduct a research work. The title of my research is "Total Quality Management of Hospital System and Patient Satisfaction in Bangladesh: A Comparative Study between Selective Private and Public Hospital in Chattogram City". This is purely academic. Some information is needed from you in this regard. This information will be used only for this study and confidentiality will be maintained strictly. I seek your kind co-operation as much as possible. Your co-operation would highly be appreciated.

Name:
Address:
ID No.:

Questionnaire

Part-A

1.	I hope, your organization gives you the recognition you are looking for.	a) Highly Disagree b) Disagree c) Neutral d) Agree e) Highly Agree
2.	Does every employee in this hospital goes through an annual reward system (performance evaluation protocol)?	a. Every year b. Not every year c. Rarely d. Very Rarely e. Never
3.	Do you believe, senior management support leads to job satisfaction among the employees?	a) Yes, I do b) No, I don't c) Not sure

4.	Do you feel that you can trust your colleagues & Senior staffs?	a. Yes, I do b. No, I don't c. Not sure
5.	Is there the team work spirit in your work environment?	a) Yes b) No c) Not Sure
6.	Have you attended previous regular quality management training by your hospital management?	a. Yes, I have b. No, I haven't c. I could not somehow d. I was not enlisted
7.	Do you think, learning and skill development have been continuously developed among the employee through proper training / guideline / instruction and education by the management?	a) Yes, I do b) No, I don't c) Not sure
8.	Does your hospital provide adequate training/education to improve skills and performance in infectious hazards handling?	a. Yes b. No c. Not Sure
9.	Does your hospital provide adequate training/education to improve skills and performance in medical waste handling?	a) Yes b) No c) Not Sure
10.	Does your hospital provide adequate training/education to improve skills and performance in following SOP of individual work procedure properly?	a. Yes b. No c. Not Sure
11.	Do you think, the Hospital Management has been applying sufficient efforts towards implementing TQM across the organization?	a) Yes, I do b) No, I don't c) Not sure
12.	All the Staffs are trained/educated about problem-solving skills.	a. Highly Disagree b. Disagree c. Neutral
13.	Do you think, patient well-being/well-fair oriented strategies are being built and reviewed for further improvement?	a) Yes, I do b) No, I don't c) Not sure
14.	Does your hospital maintains & practices safety, sanitation and hygiene practices?	a. Yes b. No c. Not Sure
15.	Do you think, all the staffs and colleagues are cooperative each other in daily activities?	a) Always b) Sometimes c) Rarely

16.	Do you think, the hospital service charge/care giving charge is rational/reasonable/affordable?	a. Yes b. No c. Not Sure
17.	Do you think the quantity of clients/patients have become increases than the previous year?	a) Yes, I do b) No, I don't c) Not sure
18.	Do you think your hospital handled and gave services effectively, strongly and very carefully during the Covid situation?	a. Yes, I do b. No, I don't c. Not sure
19.	If someone of the employee of your hospital do some mistake or do unwanted wrong in any work procedure, what your management do in reply?	a) Give punishment b) Discuss the issue c) Forgive him/her d) Do nothing
20.	Do the senior staffs are very cooperative and helpful to the junior staffs?	a. Always b. Sometimes c. Rarely d. Very Rarely e. Never
21.	Are you happy with the payment system, service rule and yearly evaluation process of the organization?	a) Yes, I do b) No, I don't c) Not sure
22.	Do you think, the monitoring system on employee responsibilities enhancing total progress of the organization?	a. Yes, I do b. No, I don't c. Not sure
23.	Do you think, the monitoring system on abiding instructions enhancing total progress of the organization?	a) Yes, I do b) No, I don't c) Not sure
24.	Do you think, the monitoring system on following SOPs enhancing total progress of the organization?	a. Yes, I do b. No, I don't c. Not sure
25.	Do you think, the organization is very much careful and responsible about the satisfaction of the clients/patients?	a) Always b) Sometimes c) Rarely d) Very Rarely e) Never
26.	Do you think, the organization is very much careful and conscious about updated and latest hospital equipment, instruments and setup?	a. Always b. Sometimes c. Rarely d. Very Rarely e. Never
27.	Do you think, the organization is very much careful and conscious about updated and latest hospital management and services as well?	a) Always b) Sometimes c) Rarely d) Very Rarely e) Never

Part-B:

Evaluation of Doctor's Service (Put score '1-5' based on level of satisfaction*):

1. Doctors service/___/
2. Availability/___/
3. Cooperation...../___/
4. Counseling...../___/
5. Carefulness...../___/
6. Visits regularly...../___/

Evaluation of Nurse's Service (Put score '1-5' based on level of satisfaction):

1. Nurses Service...../___/
2. Availability...../___/
3. Timely drug/___/
4. Politeness & sympathy...../___/
5. Regularity...../___/
6. Cleanliness...../___/

Evaluation of medicine supply (Put score '1-5' based on level of satisfaction):

1. Regular supply of medicine...../___/
2. Supply of needed medicine...../___/

Evaluation of services at reception (Put score '1-5' based on level of satisfaction):

1. Politeness & sympathy/___/
2. Courtesy...../___/
3. Conduct of the receptionist...../___/
4. Cooperative attitude...../___/
5. Open communication...../___/

Evaluation of Aya/ward boy/Cleaner (Put score '1-5' based on level of satisfaction):

1. Professional skill...../___/
2. Behavior...../___/
3. Availability...../___/
4. Cleanliness...../___/
5. Politeness...../___/

Evaluation of laboratory services (Put score '1 – 5' based on level of satisfaction):

1. Availability of Essential services...../___/
2. Cleanliness...../___/
3. Politeness&sympathy...../___/
4. Useofmodernequipment...../___/

Hospital Environment:

Cleanliness:

1. Hospitalcleanliness...../___/
2. Ward/cabincleanliness...../___/
3. Toiletcleanliness...../___/

(Principal Investigator)

N.B.:

*** Level of satisfaction will be measured as follows:**

1 = Not at all satisfactory 2 = Somewhat satisfactory 3 = More or
less satisfactory 4 = Appreciable 5 = Excellent

নিচে আপনার সেবার সাথে জড়িত প্রশ্ন দেয়া হলো, এই প্রশ্নের উত্তর দেয়ার জন্য আপনাকে আহবান করা হলোঃ

প্রত্যেকটি প্রশ্নের ডানে প্রদত্ত ১ (সর্বনিম্ন) থেকে ৫ (সর্বোচ্চ) পর্যন্ত বিস্তৃত মাপকের জন্য একটি সংখ্যা টিক (✓) দিন ।

প্রশ্নের উত্তর দেওয়ার জন্য আপনাকে অনুরোধ করা হলো। মাত্রাসমূহ নিম্নরূপ:

অত্যন্ত সন্তোষজনক : ৫

বেশ সন্তোষজনক : ৪

মোটামুটি সন্তোষজনক : ৩

কিছুটা সন্তোষজনক : ২

মোটাই সন্তোষজনক নয় : ১

ডাক্তার সম্পর্কে রোগীর মূল্যায়ন:

ক্র. নং	বিবরণ	মোটাই সন্তোষজনক নয়	কিছুটা সন্তোষজনক	মোটামুটি সন্তোষজনক	বেশ সন্তোষজনক	অত্যন্ত সন্তোষজনক
ক)	আপনি যে সেবা পান					
খ)	প্রয়োজন মাত্র উপস্থিতি					
গ)	উপস্থিত সমস্যার ক্ষেত্রে সহযোগিতা					
ঘ)	আপনার রোগ সংক্রান্ত ফলাফল সম্পর্কে তথ্য প্রাপ্তির সুযোগ					
ঙ)	উন্নত সেবার মানের ব্যাপারে অত্যন্ত সতর্ক					
চ)	নিয়মিত রোগী দেখা					

সেবিকাদের সম্পর্কে রোগীর মূল্যায়ন:

ক্র. নং	বিবরণ	মোটাই সন্তোষজনক নয়	কিছুটা সন্তোষজনক	মোটামুটি সন্তোষজনক	বেশ সন্তোষজনক	অত্যন্ত সন্তোষজনক
ক)	আপনি যে সেবা পান					
খ)	প্রয়োজন মাত্র উপস্থিতি					
গ)	ঔষধ প্রয়োগে সময়ানুবর্তিতা					
ঘ)	ভদ্রতা ও সহানুভূতি					
ঙ)	নিয়মানুবর্তিতা					
চ)	পরিষ্কার-পরিচ্ছন্নতা					

রোগীকে ঔষধ সরবরাহ:

ক্র. নং	বিবরণ	মোটাই সন্তোষজনক নয়	কিছুটা সন্তোষজনক	মোটামুটি সন্তোষজনক	বেশ সন্তোষজনক	অত্যন্ত সন্তোষজনক
ক)	ঔষধ প্রয়োগে সমায়ানুবর্তিতা					
খ)	প্রয়োজন মারফিক ঔষধ সরবরাহ					

রিসিপশন:

ক্র. নং	বিবরণ	মোটাই সন্তোষজনক নয়	কিছুটা সন্তোষজনক	মোটামুটি সন্তোষজনক	বেশ সন্তোষজনক	অত্যন্ত সন্তোষজনক
ক)	ভদ্রতা ও সহানুভূতি					
খ)	সৌজন্য ও সহমর্মিতা					
গ)	আচরণ					
ঘ)	উপস্থিত সমস্যার ক্ষেত্রে সহযোগিতা					
ঙ)	উন্নুক্ত যোগাযোগ					

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Thank You

