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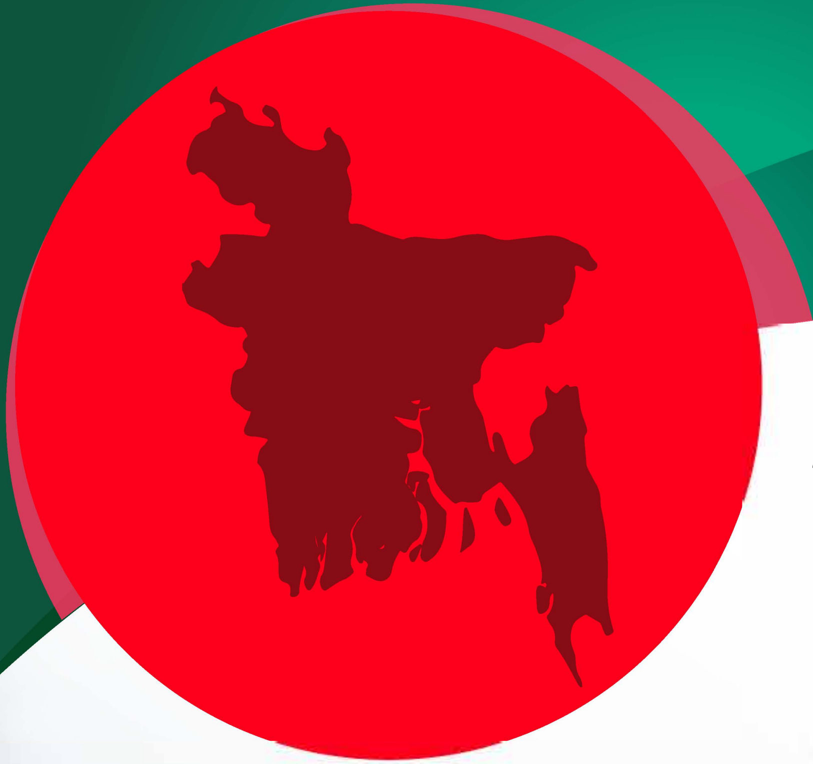

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Improving Hospital Care in Bangladesh

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Abstract

Viewed as preventive versus curative, Bangladesh's health services show a clear dichotomy. Long term indicators of the preventive type suggest significant gains in the health status of the general population including improvements in maternal and child mortality rates, as well as longevity. The curative side, unfortunately, provides a different picture; those who need hospital care often receive poor quality of treatment, including failures in patient-provider communication, empathy, assurance, and overall poor management – all representing patients' expectations from the service providers. This paper is based on action research, assessing the experiences of patients and their attendants in several hospitals/clinics via in-depth interviews. The findings suggest the need for behavior modification among service providers (doctors, nurses, technical hands, office administration, and managerial personnel) and calls for establishing educational programs in health care administration immediately, to develop a cadre of managers versed in better managing health care service delivery.

1 Introduction

Bangladesh's healthcare scenario poses an interesting dichotomy. One the one hand, macro indicators suggest that the country has made significant strides in the health sector, particularly in reducing maternal mortality rate (1.73 per 1000 in 2016 compared to 3.2 in 2001) and infant/child mortality rates (17.1 per 1000 live births in 2016 compared to 66 in 2000) and increasing life expectancy (at 71 for males and 74 for females in 2016 compared to 61 and 60 in 2000). These indicators were far more onerous at the time when Bangladesh came into being in 1971 with total fertility rates at around 6.3 in the 1970s to above 3 in the early 2000s and 2.1 in 2016 – a remarkable achievement.

On the other hand, research since the 1990s (Andaleeb 2001; Andaleeb, Siddiqui, and Khandakar 2007; Mamun and Andaleeb 2013) indicates that health services provided to those who need hospital care are of poor quality, compromising patients' expectations from the service providers. Using 'patient satisfaction' as a metric for service delivery since 2001, the above studies found that the satisfaction rating did not improve over the past two decades and remained near the average score with substantial variation in the data; i.e., the delivery of hospital (curative) care is average and uneven. In contrast, hospitals in the region (India, Bangkok, Singapore) measured on the same metric performed "significantly" better. The macro data are based on preventive care, generally delivered by non-medical personnel working as field extension agents, while the hospital data represent "perceptual" curative care delivered by trained physicians and nurses.

2 Literature Review

Studies have shown how important it is to deliver quality services and effective medical treatment by focusing on the patient's point of view (Christo and Clapton, 2014). As one of the fastest growing industries in the service sector, the health care industry will have to contend with competitive pressures, alternate health care delivery mechanisms, changing cost structures, greater accountability, increased information availability, and a markedly better-informed clientele (Andaleeb 1998). In this milieu, delivering customer satisfaction will become a crucial determinant of long-term viability and success. In fact, Donabedian (1988) suggested three decades ago that "patient satisfaction may be considered to be one of the desired outcomes of care...information about patient satisfaction should be as indispensable to assessments of quality as to the design and management of health care systems."

Studies in the developed countries have shown that the public is inclined to pay more for quality care from health care institutions which are better disposed to satisfy customers' needs (Boscarino 1992; Hays 1987). Its value as a competitive tool also derives from the fact that hospitals that are customer focused have been able to increase capacity utilization and market share (Boscarino 1992; Gregory 1986).

Attention to customer satisfaction is also imperative because today's buyers of health care services are better informed, a condition that is being driven by the abundance of information available to them from public and private sources. Today's patients are, therefore,

more discerning and are relying less on doctors to choose the "right" hospital.

Research on service quality has grown since the conceptual model developed by Parasuraman, Zeithaml and Berry (1985). According to this model, consumers' service quality perceptions are influenced by a number of gaps, reflected in the difference between performance expectations and perceptions. Hence, service quality depends on the size and direction of the gap between expected and perceived service. Service quality perceptions will be favorable if the service performance exceeds the customer's expectations or unfavorable if service expectations are not met.

Although the SERVQUAL model has made significant contributions to the service quality literature, scholars continue to debate its five dimensions and their measures: either as *perceptions* which more closely match customer evaluations of the services provided (Cronin and Taylor, 1992) or as *disconfirmation*—the difference between perceptions and expectations (Parasuraman et al., 1994).

Support for the five dimensions has been mixed and the differences in dimensionality have been attributed to the different industries in which the studies were conducted (Asuboteng et al. 1996; Kettinger and Lee 1999). Thus, Babakus and Mangold (1992) found only one dimension, while Dean (2004) found four stable dimensions. Researchers argued that up to nine dimensions of service quality may exist depending on the type of service sector under investigation. Dotchin and Oakland (1994) argued that the four service providers researched (retail banking, credit cards, brokerage, and repair & maintenance) for the SERVQUAL study were not high in consumer intervention, contact and adaptation; hence the five dimensions were not written in stone.

An alternative model to SERVQUAL was developed by Teas (1993), proposing a measure called Evaluated Performance (EP) which focuses on the gap between perceived performance and the *ideal point* on a feature instead of customers' expectations. Similarly, Spreng, Mackenzie and Olshavsky (1996) examined gaps between performance and desire.

Given the varied points of view, O'Reilly (2007) suggested the need to look at more context-specific approaches to understanding how consumers evaluate service quality. Since the participation of service users has become an increasingly important focus in quality improvement programs, the importance of active participation of the consumer was stressed in defining and evaluating service quality. Embracing the P-C-P (pivotal-core-peripheral) model proposed by Philip and Hazlett (2001), O'Reilly suggested that the service provider ought to develop the service evaluation tool. This study, therefore, takes a qualitative stance to get close to the patient and her/his attendants to identify those variables that are close to the patient satisfaction experience in the clinics and hospitals in Bangladesh.

3 Focus of this Study

The focus of this study is on *medical/hospital care*, a major concern about which is quality. While medical care quality has been studied carefully by academics and practitioners in developed countries over a few decades now, in Bangladesh such study has not been systematic. Rather, research in this area is at best sporadic, rudimentary, undeveloped, and does not reflect a consistent pattern. What is disconcerting is that the dearth of research on and evaluation of medical/hospital services obscures from public scrutiny a vitally important service that could be substantially improved.

While the cost of medical care has increased significantly over the years, overall service quality has not made commensurate improvements, taking its toll on patients and their families. Consequently, those who are able to afford it seek even basic health services outside the country. The economic implications of this exodus should be obvious. One might note how practitioners and hospitals (Apollo Hospitals, Mount Elizabeth Hospital, etc.) from neighboring countries have begun to bring desired services to Bangladesh's doorsteps.

The findings of this study ought to provide insights to medical care professionals and support staff to improve levels of service, and hence, deliver greater patient satisfaction. The findings should also provide the impetus to establish service standards and adopt strategic long-term measures to improve the quality of medical/ hospital care services in Bangladesh.

4 Methodology

This study relies on action research, "a philosophy and methodology of research generally applied in the social sciences. It seeks transformative change through the simultaneous process of taking action and doing research, which are linked together by critical reflection," (Wikipedia) to get a comprehensive picture of the medical care environment and the quality of service it delivers. In-depth interviews and observation were used to gather data from patients and their attendants.

5 Findings

The insights gathered in this segment are based on seeing from close quarters the service problems

encountered by several patients suffering from kidney and heart problems and one having undergone hysterectomy in the country.

5.1 Experiences of a Kidney Patient

- Dialysis patient acquired Hepatitis-B. Why did this happen? Who is to be held accountable? What purpose will it serve in the absence of strong laws?
- Multi-stop services increased patient suffering by being offered at different locations (X-ray; blood-tests, various other diagnostics) of the city.
- Fee-based system of care must be replaced by need-based care. Doctors come when called by the clinic, not when they should be there. This is a two-way problem: The doctor does not want patients to feel s/he is driving revenue; but how will patients know when the doctor should be consulted, especially regarding complex problems of the kidney?
- Professional caregivers operate within a very narrow technical band; attendants from home are really the ones who provide care on a sustained basis. But mistake-prone care provided by attendants at home can be detrimental or downright disastrous (administering blood pressure medication on day of dialysis, applying the wrong dose or missing a dose).
- Attendants are with the dialysis patients for 5 hours or more each time. There is no decent toilet facility for them, no drinking water, no place to rest (many caregivers from the family are older persons) and no place to get a bite if they are hungry. These clinics were certainly not seeing beyond the patient and their pocketbook.
- At the clinic, while the patient needs exercise, massage, feeding, bed pans, cleaning, and administration of drugs, who is doing all of this? The family attendants!
- Home caregivers get no instructions to follow (e.g., food charts, when to go for follow-up tests, adjustment of doses, etc.).
- For emergency needs at home, who is to be contacted? Even well-heeled patients go ashen-faced not knowing where to go in the event of an emergency. Rarely can doctors be contacted over the phone.
- Patient must adjust to clinic timings and doctors' availability instead of the reverse. (e.g., a pre-scheduled morning dialysis was shifted to the afternoon for convenience of the doctor, regardless of its effects on caregivers or patients).
- A stream of people kept going in and out of the dialysis room. There seemed to be a picnic aura, with visitors bringing in and consuming various food items from the streets. The chance of infection is very high. And the camaraderie and merriment were often loud, causing extreme discomfort to other patients.
- Flies and mosquitoes, noise, lack of clean sheets and pillows, poor temperature control, and uncertain quality of the tubes and intrusive instruments caused constant worry.
- Young internee doctors, "acting big", were mostly in the frontline for procedures and patient care. No senior doctors even sit at the clinics and are only available on being called from their private chambers. Given the traffic conditions, there is no guarantee when they'll arrive.
- Wrong procedures by the internees and junior doctors cause tremendous suffering to the patients; yet, they act as if nothing happened or that a mistake or two is to be expected.
- There are no elevators for a patient to go to the upper floors. Patients are put on a stretcher and lifted by two or three people who do not even look clean and should not be handling the patients. When the "lifters" are not readily available, the patient has to wait … indefinitely.
- The pharmacy at the clinic was not well stocked. If a medicine was not available, it had to be obtained by the patient's attendants from outside. Where it would be available was not known, especially if time was critical.
- State of cleanliness was a constant concern. Waste was not removed promptly. There was no organized hospital waste disposal system. Much of this waste was dumped in the waste water system (toilet flush) or in the municipal garbage dump where humans are known to forage for anything salvageable. There is also a worry about where the needles and tubes from a dialysis patient end up (perhaps for recycle) and where the ascites fluid (from the peritoneal cavity, causing abdominal swelling) or the blood extracted from a patient was disposed.
- Who decides when certain tests (creatinine) are needed? Usually it is someone from the patient's family who steps in for the "experts" on matters for which they are not trained (changing sleeping pill dosage; ordering suction to clear lungs, deciding what food to give, stopping certain medications because they are expensive or because they seem to be causing discomfort).
- Who decides how many dialyses are needed per week? Based on cost considerations and patient inconvenience, it is the *family* which decides on the number, without even consulting the doctor. Is this appropriate? The doctors do not want to intervene because the "decision lies with the family!"

- When a senior doctor comes in, (s)he hardly advises the patient or the family caregivers who do most of the work. From the younger staff who are advised, it is difficult to be clear on procedures. Is this because they feel bothered or is it because they have NOT understood the instructions themselves? Tremendous risks are involved if it is the second case.
- Not much instruction is ever given in writing when advising patients or their care givers. Sometimes several instructions are given verbally. There are two problems here: i) What if all the instructions are not well understood by the patient/attendant (and if you question the doctor, you could get a queer look as if saying 'how stupid can you be'? ii) Can so many instructions be remembered?
- Some doctors do not like questions. If s/he says the patient is okay, you have to accept it; you cannot even ask for a blood pressure or pulse rate reading; you could get a condescending look saying "Hey, who is the doctor here?"
- When a doctor comes into a patient's room, he has this "imperial" air and expects everyone (including the senior people in the room) to remain standing in his/her presence while s/he examines the patient; otherwise, s/he could look you up and down. When speaking to her/him, it is expected that it must be done with awe and reverence! Whatever happened to the patients' side? "We are paying for services, they are not doing us a favor" says an attendant.
- The ambulance service, if it can be called so, is a joke. It is run by a driver and a helper who clears the traffic. There are no paramedics in the vehicle. It is not air-conditioned, although a tiny fan is attached to the seat behind the driver and ill-directed. There is also an oxygen cylinder in the vehicle, but it looks so beat up that one wonders if it works to save lives. Assuming it works, it is quite apparent that the two vehicle operators have no clue as to how to operate it.
- The stretcher on which the patient is carried is narrow (not apt for heavier patients), dirty (is it ever cleaned), and has no straps. The attendants have to hold the patient, one near the mid-section and another near the head to stop the patient from rolling off (more like flying off). There is much swerving to endure since no vehicle stops for the ambulance to pass … even when the siren is wailing continuously; in fact, vehicles with diplomatic plates have been seen to overtake the ambulance and block its path to get ahead.
- If the patient experiences any problem or discomfort, especially during late hours in the clinic, some attending doctors expressed irritation at being called.

5.2 Experiences of a Heart Patient

- The patient felt that you can only get a good doctor if you know someone. Without connections, you don't know what you are getting. The waiting line to see a reputed doctor is also long.
- In a group practice, patients are often made to see different practitioners in the name of expertise: Each time, the patient has to pay separately; to many, this is seen as a rip off. But the patients are at their mercy.
- This heart patient cited another patient's case who wanted a particular doctor to perform a procedure on her. The doctor, however, refused to do so because he felt the case was complicated and if he "lost" her, his reputation would be tarnished!
- During a consultation, the doctor's mind seemed to be elsewhere and his attention lacking. If questions were asked, the doctor became irritated.
- Some specialists liked to see several patients together in this single and rather small room. There is absolutely no respect for privacy.
- The diagnostics part of medical care is truly frustrating. The patient consulted three specialists independently. With one angiogram, she received three types of advice: one said everything is fine and the discomfort experienced is due to age (no costs here), another doctor changed her medication and asked her to do a few more tests (some costs here), while the third doctor was convinced she needed to have stents inserted to give her relief (at, obviously a huge cost. Incidentally, there were several varieties of stents available, from a Toyota to a Mercedes!). Whose advice is to be relied upon?
- A visit for consultation often meant the waste of an entire day. For one thing every patient is given the same appointment time (say 4:00 PM); but the doctor does not show up until 2-3 hours after the time of the appointment. Seeking to be seen first, the patient came an hour early, only to be baffled at the wait of 2-3 hours in a small waiting room that was crowded, and not well ventilated. There too some patients had "priority." If one considers the time value of money for waiting, many patients could easily ask for a large compensation for time lost.
- A second or third opinion is patently discouraged. Subtle threats to discontinue such consultation are not unusual. In one case, a senior doctor at a recognized hospital refused to see the heart patient who had gone for another opinion and

underwent a procedure (at much less cost). The patient remarked, "It's my money and my health; I should be able to consult whosoever I please."

- On one occasion, the patient experienced nose bleeding after taking a certain medicine. When the patient tried to call the doctor, she was asked to "see" the doctor where she was charged again—full price—just to be seen for about a minute and an assurance that there was nothing to be alarmed about.

5.3 Experiences of a Hysterectomy Patient

- When there was only an hour to go, the patient was suddenly informed that a certain medication was required and that it had to be brought within the hour for her surgery to take place. Not only did this cause a good deal of stress on the patient, the attendants were also uncertain as to where to obtain the medicine. Why shouldn't a fairly large private hospital be stocked with the medication that patients need? One doctor answered: patients are asked to provide medicine and supplies because, apparently, sometimes patients slip away from the hospital without paying their bills!
- The day after the operation, the patient experienced considerable pain. Approaching the nurse's bay, her attendant found only one nurse and she was on the telephone. The conversation was animated and long – apparently a personal call. Until the call was completed, the attendant was reluctant to break into the conversation, fearing reprisals from the nurse that could contribute to further patient discomfort or worse.
- Patient care has to be provided by personal attendants, whether they are family members or hired help, while the patients are in the hospital. On one occasion, the patient was under sedation and the attendant had stepped out for a couple of hours. The patient came to her senses before the attendant returned and needed assistance. But there was no device near her to call someone, nor was there any regular checking by the hospital staff. Why this complacency? Do the hospitals expect someone to be with the patient 24 hours?
- The hospital seemed to have no rules about patient visitations: anyone could drop by any time. Such visits caused distress. The hospitals need to establish and enforce visitation hours.
- The cleaning staff (aya) was very helpful when they were given baksheesh but seemed to disappear when not given such extras. It also seemed like the hospital was understaffed at the lower levels, forcing much of the grunt work on the patient's attendants. This was similar to the case of the kidney patient.

6 Discussion

The delivery of medical/hospital care in Bangladesh must improve substantially. The findings of the study suggest the need to bring about behavioral changes among the doctors, nurses, and support staff to deliver quality services. But focusing only on doctors, nurses, and support staff, and changing their behaviors will not be enough. There are deeper organizational issues and a need for greater commitment of the higher authorities of the health ministry, as well as the development partners who must jointly demonstrate a spirit of service to alleviate Bangladesh's curative health concerns and challenges. Better yet if there is also community participation in the matter of service delivery. Without these elements, medical/hospital care providers will not be able to bring about perceptible changes and provide more comprehensive solutions to make medical/hospital services work better.

6.1 Behavior Change Models

Among the behavior change theories, *social influence theory* can play a large role to change service providers' behaviors. According to Kalkhoff and Barnum (2000 p.95), "Social influence has interested social psychologists for many years. From the classic studies of conformity and obedience to explorations of persuasion, status, and in-group bias, researchers have provided us with fascinating, non-obvious findings on how human actors lead one another to modify their actions and beliefs."

Theoretical developments in this area suggest several reasons why social influence works. Myers (1993) and Solomon (1996) summarize earlier work in the field and suggest that people conform to influence for two reasons: *Normative influence* gains conformity based on a person's desire to fulfill others' expectations, often to gain acceptance. In other words, people tend "to avoid rejection, to stay in people's good graces, or to gain their approval" (Solomon, p. 246). *Informational influence* on the other hand suggests that people conform by accepting evidence about reality provided by other people, especially when that reality is ambiguous. According to Myers, "concern for social image produces normative influence. The desire to be correct produces informational influence."

Schiffman and Kanuk (1994) add a third source of influence: *utilitarian influence*. This is where people conform with the wishes of others in order to obtain a reward (acceptance) or avoid punishment (rejection). Under this category, we note *operant conditioning theory* where emphasis is placed upon consequences which follow behaviors – rewards for desirable and punishment for undesirable behavior. Thus, behavior change occurs or is anticipated when certain conse-

quences are "contingent" upon certain "target behaviors." In applying this theory, various strategies such as positive reinforcements, negative reinforcements, punishment, and extinction can be applied judiciously to bring about desired behavioral changes.

The above sources of influence can serve as powerful bases for attempting to bring about needed changes at the service delivery level. These approaches may be grouped under a powerful source of conformity: *evaluation as social influence*. In fact, evaluation as social influence is a branch of social influence theory that addresses the notion of "evaluation apprehension" which focuses on individual apprehensions about how others are evaluating us (Cottrell et. al. 1968; Worringham and Messick 1983; Bagozzi and Lee, 2002). Evaluation may hence be seen as accountability: A good evaluation accrues to desirable behavior or performance, a negative evaluation to undesirable behavior or performance.

Evaluation spans normative influence in that service providers would want to meet evaluation criteria and fulfill expectations of the system to gain acceptance. Evaluation also serves as informational influence by providing evidence about reality (deviations from performance standards) to which people adjust and conform. It is important, however, to distinguish between evaluation as a process and evaluation as an outcome. Evaluation as a process involves setting standards or goals and setting up a measurement system to account for whether the goals or standards are being met. It involves who will measure what and when. Evaluation as an outcome is the end-result of the process based on which consequences follow.

6.2 Need for Standards

An important element in conducting effective evaluation is having "standards" or "goals." These standards would have to be developed, communicated, adopted, and adhered to by all members of the group, thereby institutionalizing them. The standards become benchmarks (which can evolve) against which both positive and negative deviations can be observed. When performance is evaluated, the information will help the service providers conform to the standards, especially if there is significant departure. For utilitarian influence to come into play, appropriate rewards and punishments could be designed for nonconformance, conformance, or exceeding expectations.

Unfortunately, the patient-care system does not seem to have any predefined or agreed upon standards or goals. It is imperative, then, for a lead agency to formulate some basic standards for the hospitals against which performance of health care providers can be assessed periodically.

In fact, standards need to be established not just for the service providers but also for other levels of the system (e.g., Directorate General of Health Services) to make the curative part of healthcare delivery system become more effective. The use of evaluations is not necessarily meant to be punitive; the information should actually be used for development of the entire sector.

6.3 Evaluation and Accountability

Seeking behavior change at the service delivery level will only be successful if system-wide standards are in place – not only for healthcare providers and the facility they run, but also the management at all levels of the hierarchy (both public and private), and the lead ministry, Ministry of Health and Family Welfare, responsible for setting healthcare strategy at the national level. The standards for any level must be simple and easy to measure. At the same time, those responsible for conducting the evaluations must, to the extent possible, be external to the level or unit of the system being evaluated although self-evaluations are also not inappropriate to use. However, their use in allocating rewards ought to be carefully scrutinized.

A certification program may be developed and administered by professionals from the health care area. Those responsible for conducting technical evaluations must only develop, maintain, and upgrade the program with strict oversight responsibilities. To gain public trust, use of external expertise or some combination of external and local expertise may be needed to set up and administer the certification process.

It is also important for the certification process to be understood by the general public. Thus, it must have components (e.g., five-star ratings of hotels) that they can comprehend. In addition, certification information must be widely available to the public through mandated hospital and related information centers to serve as quality indicators and to help the public make informed choices.

6.4 Evaluating Healthcare Service Facilities (Clinic, Diagnostic Centers, etc.)

Patient's Perspective: Patients should not only rate the interactive skills of the service providers; they may also rate the facility in terms of cleanliness, signage, clarity of pricing of the different services, information availability on various services, availability of waiting areas, comfort in waiting, toilet facilities and so on. These ratings could be provided to regulatory agencies on a regular basis. It goes without saying that it would be important to determine, specify, and strongly enforce sanctions for tampering with patient evaluations.

Polling by Watchdog Organization: Various types of health facilities should also be evaluated by organizations unconnected with any health service delivery. These could be universities, NGOs, research centers, etc. to obtain an independent evaluation of the various service facilities. If a ranking mechanism can be established, the watchdog organizations could actually make the rankings public so that people are aware of the strengths and weaknesses of the various facilities to help in choosing the right facility. For the facilities, the social stigma of being rated low should also serve to foster a competitive environment for better ratings.

A continuous stream of such studies could influence complacent health care providers to respond to established standards and public expectations. If the pride and professionalism of these organizations, and the people representing them, can be provoked through continuous evaluations, the long-neglected health care customer is likely to get a better deal.

6.5 Enabling Health Personnel

Any evaluation system is bound to fail if the feedback received is not "utilized' to maintain the system in shape. A major requirement here is to "enable" the personnel to do what they are supposed to do. If drugs are not available where and when needed, there is a system failure; if technical equipment needed to diagnose medical conditions is not operational, there is a failure; if patient demand is high during an epidemic, not making the full staff available and responsive is a system failure. These examples show when the system is not properly enabled, it underperforms, leading to many dissatisfactions.

Research also suggests that the size of the workforce, especially for public delivery of healthcare is grossly inadequate. For example, in 2000, there was 1/4512 physician per population, 1/10,714 nurse per population and 1/3,261 hospital beds per population. In 2016 these numbers were 1/2119 for doctors and 1/3745 for nurses (including midwives). These overwhelming numbers suggests that the internal systems must be restructured and revitalized. For example, front-line personnel—doctors and the support staff—are among the most vital resources contributing to the success of health care delivery. If they remain overwhelmed and their job satisfaction is low, service will suffer.

In fact, "service research" suggests that employee satisfaction and customer satisfaction feed off each other: satisfied employees reinforce customer satisfaction, which in turn reinforces employee satisfaction. It has also been suggested that unless organizations are able to generate internal harmony and satisfaction among the employees through the establishment of a "cycle of capability," the employees may not be predisposed to deliver what is required of them. This means that significant effort must be devoted to hiring the right personnel, developing them, providing them with needed support, compensating them, and devising ways of retaining the best among them. This calls for enabling them by training employees in both technical and interactive skills, empowering them, developing internal processes and supporting technology, and treating employees like "internal" customers to be equipped for the job they perform.

7 Conclusions

A stronger managerial orientation should be introduced in various tiers of the health system to help deliver quality services and patient satisfaction. Unfortunately, modern managerial practices seem to be lacking in most hospitals. This situation may be attributed partly to the fact that the control of hospital management remains in the hands of physicians who are trained mainly to heal the afflicted, not to manage and administer hospital operations. Thus, they must be assigned to health care facilities to heal patients, not to administer the functioning of the facility in areas such as purchasing, recruiting, promotions, conflict resolution, etc.

It is urgent, therefore, to introduce educational programs in health care administration to develop a cadre of managers versed in the management of health care. Their job would be to ensure the right level of staffing, staff development, compensation, reward systems, purchasing, public relations, conflict resolution, and other managerial functions. While these professionals may also need some training in health care, they do not need a medical degree. This would help bring about a better managerial orientation in the health care sector, freeing up doctors to attend to the needs of the ailing. It is time to be proactive to bring about behavioral and structural changes to the delivery of health care and make patient satisfaction central to this vital service.

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