

## An Empirical Study on Various Healthcare Strategies Followed by Selected Hospitals in Puducherry

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### ABSTRACT

India is a prime example of a nation that has seen significant change in the expansion of the global healthcare industry. It is a nation with a wealth of medical expertise and ability, giving it an advantage in the medical industry through a variety of health service offerings. Patients from all over the world come India for treatment due to its medical expertise. However, the rate of development in the Indian medical industry does not reflect the reality that it has faced numerous challenges both historically and currently. Even though India is one of the biggest providers of health care services, it still has many flaws, including unregulated competition, poor service quality, high costs, the dominance of private health care players, insufficient resources, a narrow focus, and a deteriorating public health care sector. Aside from this, it is a common rural-urban imbalance that rural areas have far less access to medical care than metropolitan ones. As a result, there is a considerable demand for health care, yet there are insufficient financial and administrative resources to satisfy it. In this regard, the current study aims to evaluate different healthcare practices used by a chosen hospital in Puducherry.

**Keywords:** global healthcare industry, medical expertise, unregulated competition, public health care sector, financial and administrative resources, hospital in puducherry

## I. INTRODCUTION

The National Health Policy of India states that in 2002, the principles for a number of important priorities and operational choices were already set. It did not, however, lay out a strategy for meeting all of the country's population's health demands. India, on the other hand, is currently one of the economies in the world with the fastest growth rates, according to literary sources. The Bhore Committee described a primary health center as an entry-level facility for the delivery of healthcare services in their 1946 report. The Indian healthcare industry, which has been named one of the fastest-growing industries, is anticipated to develop at a CAGR of 22.87 percent between 2015 and 2020, reaching US \$280 billion by that year. The NHP recommendations concentrated on the medical conditions that were most important to the causes of illness. The obligation will primarily rest with public health administration, which shall identify the options for resolving India's health issues. This is not to say that other aspects are not significant for the critical regions of the country will be ignored. The policies have a number of objectives to meet in order to measure patient satisfaction. The state of one's health plays a crucial role in assessing social, demographic, and quality of life advancements that lead to fundamental human rights. One of the biggest problems facing health systems today is ensuring that everyone has access to unbiased health care services, regardless of their capacity to pay for such treatments. Being an agrarian nation, the majority of Indians have traditionally lived in rural areas, and today, about 75 percent of the country's 1.2 billion people still reside there. Despite this, the Indian market is expanding in terms of typical revenue levels. Rapid urbanization also adds to the strain on medical insurance policies. The Indian healthcare market, according to NASSCOM, was valued at USD 1 billion in 2016 and is anticipated to increase by 2.5 times by 2025.

The healthcare sector in India now offers both established and emerging firms a wide range of opportunities to acquire new technologies, competitive advantages, and financial success. The key competitive advantage that medical professionals in India have over their rivals is their skill and training. Additionally, India has a significant economic advantage over its peer nations in Asia and Western nations due to the fact that surgery in India costs about one-tenth as much as it does in the US or Western Europe. The diagnostics industry in India has also experienced unimaginable transformation throughout the years, leading to a significant increase in its innovation, competence, and performance potential.

In addition to allopathic hospitals, the country's 3,598 hospitals and 25,723 dispensaries use AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homoeopathy) treatment, which makes alternative medicines available to the public. The Millennium Development Goals (MDGs) place a tremendous amount of responsibility on us, especially in the

field of health. As determined, three of the eight goals are connected to health. India has been found to have fallen short of the MDG targets for health indicators in terms of significant growth. In addition, India's aging population places a significant strain on its healthcare infrastructure and services. As a result of the significant shortages in qualified health professionals like doctors, lab assistants, medical technicians, and nurses, as well as in physical facilities, there has been a reduction in the number of patients. Although private providers have shown a keen interest in collaborating with the government on a variety of agendas and projects, including primary health centers, emergency and women's and children's health centers in public hospitals, as well as health insurance schemes, the increasing standard of living, more information on health awareness, an expanded lifestyle, and access to insurance could be some of the ways to achieve these goals.

The central government-owned and -supervised Institutes of Medical Sciences in India provide the healthcare services through referral hospitals. These institutions operate at AIIMS Delhi, AIIMS Bhopal, AIIMS Bhubaneswar, AIIMS Jodhpur, AIIMS Raipur, and AIIMS Rishikesh among others and offer super speciality services. The respective state and federal governments share oversight of the hospitals and research centers that provide cancer care. Additionally, there are Government Medical Colleges that are governed by the corresponding state governments. Referral hospitals are available besides these. General or District hospitals are under the supervision of the relevant state governments and serve the relevant districts.

In urban and rural locations, taluk hospitals serve as community health centers and basic health units. The fundamental units are typically run in rural India. The unification of all current National Health Programs under the umbrella of the National Rural Health Mission was one of the healthcare goals in the 12th Five Year Plan, according to experts. "All organized measures (whether governmental or private) to prevent disease, enhance health, and extend life among the population as a whole," is how public health is described. Its efforts center on entire communities rather than simply a small number of patients or illnesses in order to create the environment necessary for everybody to be healthy (World Health Organization, 2014.)

## II. HEALTHCARE FACILITIES IN PUDUCHERRY

In several national-level tendencies relating to health care, Puducherry is well ahead. For instance, when compared to the national median when it comes to health indicators, the union territory exhibits impressive numbers. The eleventh five-year plan, which covers the years 2007 to 2012, states that Puducherry's newborn mortality rate is 22 whereas the national median is 30.

According to a recent report from the Department of Health and Family Welfare of Puducherry, the union territory boasts the best health care delivery system in the country, with the average distance between residents and medical services being less than 0.733 miles.

Health is considered as a fundamental right. The state has the responsibility to enforce the right. Illness becomes a most profit producing industry and many private hospitals are exploiting the poor patients. 80% of medical expenditure of the poor people is from out-of-pocket and 25% of hospitalized patients are drifting into poverty. The Health Care in the Union Territory of Puducherry has been delivered through a network of 8 major Hospital, 4 CHCs 39 PHCs, 81 Sub-Centres, 14 ESI Dispensaries, 1 Physical Medicine

Rehabilitation Centre and 17 Disease Specific Clinics. Annually over 57 lakhs out patients and over 1.40 lakhs inpatients are treated in these 164 health care centres/Institutions. Now efforts have been taken to deliver a quality medical care in all the health institutions. All the CHCs, PHCs & Sub-Centres will be strengthened.

The Health Care in the Union Territory of Puducherry has been delivered through a network of 8 major Hospital, 4 CHCs 39 PHCs, 77 Sub-Centres, 14 ESI Dispensaries and 17 Disease Specific Clinics. Annually over 57 lakhs out patients and over 1.40 lakhs inpatients are treated in these 159 health care centres/Institutions. In the Health Care Delivery Services, the Union Territory of Puducherry has been adjudged as the best in the country. This effective implementation of Five Year Plans has ensured accessible medical care within an average distance of less than 1.18 kilometres.

The Health Care system is being implemented in the Union Territory of Puducherry through various Schemes in the Health Sector with a view to provide preventive and curative health care by health protection, promotion and rehabilitation.

Apart from PHC and government hospital there are around 100 private hospital functioning in puducherry which are providing world class treatment to the needy people in a cost effective manner.

### 2.1 Primary Health Centres (PHCs)

Through 39 large primary health centers, often known as PHCs, the population of the union territory is provided with basic health care. In addition, Puducherry is home to 77 sub-centers that provide medical and nursing services, such as anti-rabies vaccinations for acute viral diseases of the nervous system, insulin shots for those with diabetes, and anti-snake vaccinations for snakebites. Internet access is available at Puducherry's primary healthcare facilities, and a second auxiliary nurse has been hired.

## 2.2 Community Health Centres (CHCs)

The people of the union territory can access secondary health care through Community Health Centers, or CHCs for short. Four community health centers are now located within the administrative boundaries of Puducherry. Karikalampakkam CHC, Mannadipet CHC, Thirunallar CHC, and Pallor CHC are some of Puducherry's CHCs. In Puducherry, community health centers provide cutting-edge medical care to the area's rural residents, while specialized clinics are directed to help people with high blood pressure and sugar complaints.

## 2.3 Tertiary Care

Government general hospitals, which are crucial to the union territory's health care infrastructure, are where Tertiary Care is provided. The primary referral facility for basic and secondary healthcare facilities in Puducherry is Tertiary Care. Eight government general hospitals that provide patients with speciality and super-specialty medical care are currently located in the Pondicherry, Yanam, Mahe, and Karaikal regions of the Puducherry Union Territory. In reality, there are roughly 5200 patients cared for daily, and the infirmaries are equipped with cutting-edge medical facilities like research labs, operating rooms, and accredited blood banks.

## 2.4 Preventive and Curative Health Care

The Department of Health and Family Welfare of Puducherry has launched numerous preventative and curative health programs for tuberculosis (TB), leprosy, and vector-borne diseases (diseases brought on by contagious microbes), as well as dental wellness programs and many other health initiatives. The Puducherry Department of Health and Family Welfare has implemented a number of health programs, some of which are: Family Welfare Program, Physical Medicine & Rehabilitation Center, and National Anti Malaria Program

# III. REVIEW OF LITERATURE

Digital health interventions (DHIs) have a great deal of potential as support modalities to diagnose and control cardiovascular disease (CVD) hazard in resource-constrained settings, but research evaluating them have only small effects, according to Schierhout, G. (2021). This study aims to explain how and in what contexts the intervention was effective by identifying variation in the outcomes and application of SMARTHealth India, a spatial randomized trial of an ASHA-managed digitally enabled primary healthcare (PHC) service strengthening strategy for CVD risk management. Using focus groups with ASHAs (n = 14) and interviews with ASHAs, PHC facility doctors, and fieldteam managers (n = 12), we analyzed trial outcome and implementation data for 18 PHC centers. We created mechanism-based explanations for the results that were observed, drawing on realism evaluation principles and an explanatory mixed-methods approach. Results The primary outcome showed a significant between-cluster variance (overall:  $I^2 = 62.4\%$ ).

Moradhvaj and N. Saikia (2019) There is no evidence of gender difference in HCFS for inpatient treatment, despite the extensive research on health-care expenditures (HCE) and health-care financing methods (HCFS) in low- and medium-income countries. We looked at gender differences in HCE and HCFS for inpatient care among individuals 15 and older in India, a country notorious for sex-selective abortion, poor nutrition, and limited access to healthcare. We examined the association between the gender of adult patients and HCE as well as the sources of health care finance using information from such a representative sample large-scale population-based survey. To investigate how gender affects HCE and the sources of funding for inpatient treatment, we utilized cross-tabulation, a random variable model, and multivariate regression logit regression. In adult age groups, women have fewer average HCEs than males, independent of the illness and length of hospital stay. After accounting for other patient background characteristics, this conclusion remained unaltered. When paying for health care requires borrowing, selling possessions, or contribution from friends and family, discrimination against women is exacerbated (distressed financing). The chance of stressed financing is lower for women than for men, according to multinomial logit statistics. According to the expected likelihood of using health care financing, adult men's health is valued higher than adult women's in terms of turning to distressed finance. Adult female patients' HCE is consistently lower than adult male patients' HCE. Additionally, through disrupted HCFS, women in India have reduced access to inpatient care.

Renganathan, R(2016) In order to preserve profit with the fewest expenses possible and avoid competing in the oversaturated market, the blue ocean approach involves creating or entering any industry or firm into an undiscovered new market. Service industries have a spectacular impact on a nation's economic success in today's globalized world. Due to its massive revelation, services, and escalating revenues by both public and private participants, the healthcare industry in India is expanding at an astounding rate. In India, the health care industry is among the most important in terms of both employment and money. India is seeing an increase in medical tourism because to its knowledge, workforce, cost-effectiveness, and government regulation. In this case study, the use of the Blue Ocean approach in the healthcare industry is discussed, along with the growth of corporate hospitals and medical tourism in India.

Using a study and synthesis of more than 25 years' worth of worldwide academic research and literature, Evans (2013) investigated the development of health care integration techniques and related conceptualization and practise. Methods: PubMed and EMBASE were used to perform a literature search in the field of health sciences. A strategy content model for systems-level integration was used to assess thematically 114 articles that were chosen for inclusion. Findings-

Six significant, interconnected shifts in integration strategies were identified: (1) from a focus on horizontal integration to an emphasis on vertical integration; (2) from acute care and institution-centered models of integration to a wider focus on community-based health and social services; (3) from economic justifications for integration to an emphasis on improving care quality and creating value; and (4) from evaluations of integration using an organisational perspective to evaluations using a consumer perspective. We suggest that many of these changes are driven by an increasing appreciation of the need of comprehending health care integration and delivery as complex adaptive system processes (CAS)

According to Mészáros' (2013) research, Hungary has a high rate of burnout and depression among medical workers. There aren't many empirical studies on illness prevention in these groups, however. The purpose of this research is to determine how effective coping strategies are in preventing depression and burnout. Methods: 1333 healthcare professionals participated in a cross-sectional survey. Participants answered questions on their preferred coping mechanisms, perceptions of job stress, burnout, and depressive symptoms on self-administered questionnaires. Structural equation modelling was used to conduct the analyses. Results: The incidence of serious depression was 5.6% and that of lacking in personal achievement was about 50%. Workplace stress predicted burnout and depressive symptoms both directly and indirectly via the use of coping mechanisms. Among the coping mechanisms, cognitive restructuring—which emphasises the honest appraisal of difficult situations—has been shown to lessen the likelihood of developing symptoms of depression and burnout. Conclusions: This research adds to the body of knowledge on cognitive interventional methods and underlines their significance in preventing burnout and depression in Hungarian healthcare workers.

According to Mosquera (2014), Colombia has a market- and neoliberal-based healthcare system. In 2004, the administration of the country's capital, Bogota, decided to create a health plan that included the execution of a comprehensive primary health care (PHC) strategy. The goal of this research is to identify the factors that support and hinder the establishment of PHCs in Bogota. Methods: A qualitative multiple case study technique was used in the investigation. There were seven places in Bogota listed. 14 FGDs (one focus group with staff and one with community people) and 18 semi-structured interviews with key informants (decision-makers at each locale and members of the District Health Secretariat) were conducted. Thematic analysis was used to analyse the data. Results: The primary facilitators identified at the local and district levels followed a consistent pattern and were all connected to the goodwill and dedication of actors at various levels. The neoliberal approach of national policies and a health system, the absence of a reliable funding source, the rigid and confusing regulations, the high turnover of human resources, the lack of family focus and community orientation competencies among health workers, and the limited involvement of institutions outside the health sector in generating intersectoral responses and promoting community participation were among the barriers. In conclusion, the national health system's market-based philosophy has to be overcome. In addition to establishing readily accessible and reliable financial resources for the PHC approach, interventions must be planned to incorporate highly motivated and skilled human resources.

Hoomans (2014) conducted economic evaluations that can help with decisions regarding the effectiveness and resource allocation for implementation strategies—strategies specifically created to inform healthcare professionals and patients about the best research evidence currently available and to improve their use of it in their practises. These tactics are becoming more and more common in the healthcare industry, particularly in light of rising concerns about the quality of service and resource shortages. Yet these worries scarcely seem to have prompted health authorities or other decision-makers to budget for any kind of economic analysis when evaluating implementation plans. This editorial discusses the significance of economic assessment in the context of implementation science, focusing on the best way to include these studies into discussions on implementation techniques.

The essential components and characteristics of a platform for delivering mental health treatment and its delivery channels were described by Shidhaye, R. (2015). They include the use of this platform to provide evidence-based treatments as well as larger health system strengthening tactics for more effective and efficient service delivery. The health systems approach is emphasised rather than simply disorder-focused intervention analysis. Under the WHO pyramid framework of self-care, primary care, and specialist care, a number of evidence-based treatments have been discovered; the key difficulty is in putting that evidence into practise. These interventions must be delivered in a way that adheres to fundamental public health principles, embraces systems thinking, encourages participation from all levels of government, and is quality improvement-focused. Strengthening human resources, integrating mental health into general health care, and collaborating phased care are important tactics for effectively translating findings into action. Policy makers must interact with a variety of stakeholders and utilise the best available evidence in a transparent way in order to pursue these ideas and objectives utilising a platform-wide approach.

According to Hanseth (2015), standards have been crucial to the growth of contemporary organisations but are often overlooked. The expansion of big commercial and governmental infrastructures in today's tumultuous globalisation processes emphasises this significance. In this essay, we examine the connections and conflicts between service innovation and standardisation initiatives in the healthcare industry. Seven longitudinal case studies from the Norwegian health care industry that were gathered and examined over a 20-year period serve as our empirical data. We distinguish between anticipatory standardisation, integrated solutions, and flexible generification as three general standardisation methodologies. In contrast to the flexible generification approach, we contend that the first two options do not encourage service innovation. We believe that the development of the ICT-enabled service economy will benefit from our findings.

In a study and synthesis of more than 25 years of worldwide academic research and literature, Evans(2015)examined the development of health care integration techniques and related conceptualization and practise. Methods: PubMed and EMBASE were used to perform a literature search in the field of health sciences. A strategy content model for systems-level integration was used to assess thematically 114 articles that were chosen for inclusion. Findings-Six significant, interconnected shifts in integration strategies were identified: (1) from a focus on horizontal integration to an emphasis on vertical integration; (2) from acute care and institution-centered models of integration to a wider focus on community-based health and social services; (3) from economic justifications for integration to an emphasis on improving care quality and creating value; and (4) from evaluations of integration using an organisational perspective to evaluations using a consumer perspective. We suggest that many of these changes are driven by an increasing appreciation of the need of comprehending health care integration and delivery as complex adaptive system processes (CAS). Originality/Value: This study creates a descriptive framework that may be used to evaluate, contrast, and monitor the development of integration techniques.

Gross, R. (2021)Poverty-related inequities manifest early in life in growth, particularly obesity, and in the development of the cognitive, linguistic, and social-emotional as well as the physical aspects of life. To reduce inequities, it is essential to create efficient promotional campaigns for good parenting and pregnant practises. Pediatric primary care settings provide universal access, high engagement, and population-level effect at affordable prices for basic preventive treatments. Although many low-income or poor families might benefit from preventative programmes linked to both growth and development, most effective interventions have a tendency to concentrate on just one of these areas. In this article, we make the case that it would be able to successfully and concurrently handle both development and growth. As a final shared route for both domains, current theoretical models specifically point to alignment in the processes through which poverty might impede parent-child early relational health (i.e., parenting practises, building structure, and parent-child relationship quality). We suggest a strength-based, whole-child strategy to address common antecedents via effective parenting and avoid inequalities in both development and growth based on these models and relevant empirical evidence. We think this approach has the potential to revolutionise policy and practise. In order to achieve these objectives, new payment models that enable the expansion of primary prevention in healthcare, funding for research to evaluate efficacy/effectiveness and guide implementation, and cooperation among early childhood stakeholders—including clinicians from various specialties, academic researchers, and policymakers—are necessary.

#### IV. OBJECTIVES OF THE STUDY

To assess the effect of healthcare strategies adopted by selected hospitals on overall patient satisfaction

#### V. HYPOTHESIS OF THE STUDY

**Null hypothesis (Ho):** There is no relationship between the effect of healthcare strategies adopted by selected hospitals on overall patient satisfaction

**Alternate Hypothesis (H1):** There is a significant relationship between the effect of healthcare strategies adopted by selected hospitals on overall patient satisfaction.

##### 5.1 Analysis and Interpretation

Analysis has been carried out in order to study the aforementioned goal. The current study uses ANOVA to deal with the various comparisons that have been made in it. This test eliminates some of the issues that arise when we do hypothesis testing on two parameters at once while still allowing us to study the parameters of many populations simultaneously. To perform an ANOVA, the hypothesis H0 must be tested. The study also investigated the ANOVA technique to examine the variations in the caliber of healthcare services provided by healthcare organizations and to test various techniques.

The statistical interference method known as Analysis of Variance, or ANOVA, enables us to work with several populations. Procedures for statistical inference that focus on comparing two populations typically cannot be used to three or more populations. We require various kinds of statistical techniques to analyze more than two populations at once. Therefore, the ANOVA technique has been used to track differences in hospital-specific techniques as well as in the standard of care provided by the hospitals involved in the study. The average, the standard deviation, the standard error, and the item response rate for the returned surveys were calculated for each method. When determining composite scores, each question was equally weighted. The following are the descriptive results:

**ANOVA for Differences in Strategies Followed at Various Types of Hospitals Selected for the Study**  
**ANOVA - Organizational Opportunity and Design**

		SUM OF SQUARES	DF	MEAN SQUARE	F	SIG
Organizational Opportunity and Design	Between Groups	17.649	3	5.883	37.447	.000
	Within Groups	63.625	405	.157		
	Total	81.273	408			

Source: Computed From Primary Data

**ANOVA - Standardization Operating Procedures**

		SUM OF SQUARES	DF	MEAN SQUARE	F	SIG
Standardization Operating Procedures	Between Groups	10.365	3	3.455	24.945	.000
	Within Groups	56.096	405	.139		
	Total	66.461	408			

Source: Computed From Primary Data

**ANOVA - Employees Welfare and Benefits**

		SUM OF SQUARES	DF	MEAN SQUARE	F	SIG
Employees Welfare and Benefits	Between Groups	82.785	3	27.595	51.007	.000
	Within Groups	219.105	405	.541		
	Total	301.890	408			

Source: Computed From Primary Data

**ANOVA - Strategies Related to Resources Management**

		SUM OF SQUARES	DF	MEAN SQUARE	F	SIG
Strategies related to Resources Management	Between Groups	17.649	3	5.883	37.447	.000
	Within Groups	63.625	405	.157		
	Total	81.273	408			

Source: Computed From Primary Data

**ANOVA - Standard Administrative Strategy**

		SUM OF SQUARES	DF	MEAN SQUARE	F	SIG
Standard Administrative Strategy	Between Groups	11.508	3	3.836	11.267	.000
	Within Groups	137.890	405	.340		
	Total	149.399	408			

Source: Computed From Primary Data

**Strategy 1: Organizational Opportunity and Design**

With regard to Organizational Opportunity and Design Strategy of Private hospitals is far better when compared to the other group of hospitals with the mean difference in the group between the private hospitals with public hospitals,

private clinics and other multispecialty centres is 0.46501, 0.35602 and 0.12452 (with p value less than 0.05) which shows the mean difference is positive, indicating that there is a statistically significant difference between the Organizational Opportunity and design Strategy of private hospitals' when compared to public hospitals, private clinic followed by Other multispecialty hospitals.

### Strategy 2: Standardization Operating Procedures

When comparing private hospitals with public hospitals, private clinics, and other multispecialty centres, the mean difference is 0.33698, 0.41408 and 0.16959 (with p values of 0.00, 0.00, and 0.23, respectively, if the significance level is less than 0.05), indicating that the mean difference is positive and that there is a significant difference between the standardisation and operating procedures strategy of private hospitals and that of public and private clinics.

### Strategy 3: Employees Welfare and Benefits

It was determined that there is a statistically significant difference between the Employees' Welfare and Benefits strategy of public hospitals' and private hospitals' wh, private clinics, and other multispecialty centres, with the mean difference in the group between them being 0.40372, 1.17264, and 1.09879 (with p value 0.00, 0.00, and 0.00, which is less than 0.05 significance level). Public hospitals were leading in this category of approach when compared to others.

### Strategy 4: Strategies related to Resources Management

Between the groups of public hospitals and with private hospitals, private clinics, and other multispecialty centres for strategy Reward systems, the mean difference and significance level are 0.15444, 0.42096, and 0.45686 (with p values of 0.151, 0.01, and 0.00, which are less than 0.05 significance level), indicating the mean difference is positive. It suggests that when compared to private hospitals, private clinics, and other multispecialty hospitals, there is a statistically significant difference between the strategy groups of public hospitals. Public hospitals were leading in this category of approach when compared to others.

### Strategy 5: Standard Administrative Strategy

From the above table, for strategy relating to Standard Administrative Strategy, there is statistically significant difference in group between Private hospitals, public hospitals, private clinics and Other Multispecialty hospitals ( $p=0.00$ ). Hence It can be concluded strategy related to Standard Administrative Strategy of Private and Public hospitals are better when compared to other group of Hospitals.

## VI. CONCLUSION

In general, it has been observed that the government relies too heavily on private healthcare systems, which on average cover 78% of outpatient visits and 60% of inpatient stays. By providing top-notch services to international clients and patients as well as Indians who can afford it, private healthcare providers cover nearly all bases, from private hospitals to promoting medical tourism. The study examined the relationship between various tactics used by healthcare providers in Puducherry, including public, private, and other types, and discovered a substantial connection between the strategies and the providers' types.

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