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Article

Patient Preferences and Overcrowding Pressures at Sawai Man Singh Hospital, Jaipur: A Survey-Based Analysis of Government Healthcare Choices in Rajasthan

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Abstract:

Sawai Man Singh (SMS) Hospital in Jaipur, Rajasthan's largest government facility with 6,251 beds, faces severe overcrowding with 31.6 lakh OPD visits in 2024, a record high, up 1.2 lakh from 2023. This study explores why patients prefer SMS over other Jaipur government hospitals through a primary survey of 200 patients. Findings show 67% choose SMS for superior specialists, 56% for free full IPD/OPD services, 50% for 24/7 emergency care, and 40% for reputation, resulting in 72-91% preference rates and 78-91% retention even if offered free transfers to alternatives like Govt. Satellite Bani Park, RDBP Jaipuria, ESIC Model, and RUHS Hospitals. Preference ratings confirm SMS dominance (baseline 1.00), with competitors trailing on doctoral quality (1.15-1.43) despite better waits and facilities. Specific concerns (70-89%) highlight bypassing: 89% reject Bani Park's lack of ICU, 82% RDBP's referrals. OPD trends (2011-2024) link free schemes to 300% growth from 3,300 to over 10,000 daily visits. Challenges include infrastructure failures (2025 ICU fire), staff overload (150-200 patients per doctor), 3-4 hour waits, and safety risks. Implications include deploying specialists to peers, digital triage, and primary investments to reduce congestion by 20-25%. Future scope involves multi-city studies. This patient-centered evidence reveals tertiary monopoly as the root of overcrowding, guiding equitable reforms.

Keywords: SMS Hospital Overcrowding, Patient Preferences, Government Hospitals Jaipur, Free Healthcare Schemes, Healthcare Bypassing, OPD Footfall Trends, Rajasthan Public Health

1. INTRODUCTION

Sawai Man Singh (SMS) Hospital, located in the heart of Jaipur at Jawaharlal Nehru Marg in Ashok Nagar, stands as Rajasthan's largest government-run public facility and one of northern India's most critical tertiary care centers. Established in 1934 and named after Maharaja Sawai Man Singh II, the hospital spans approximately 28-30 acres with over 6,000 beds—precisely reported as 6,251 across 43 wards—making it a monumental complex that dwarfs many counterparts, including AIIMS Delhi in daily patient volume (HexaHealth, 2025b). Affiliated with Sawai Man Singh Medical College, it integrates comprehensive medical education, research, and super-specialty services, staffing around 255 doctors, 660 nurses, and additional paramedics to handle diverse needs from general medicine to advanced oncology and transplants (HexaHealth, 2025a).

As Rajasthan's flagship public hospital, SMS plays a pivotal role in equitable healthcare delivery, particularly

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for underserved populations. It functions as the primary referral hub for the state's 8 crore-plus residents, while attracting patients from neighboring states like Haryana, Uttar Pradesh, Madhya Pradesh, and Punjab due to its free or subsidized services under schemes such as Ayushman Bharat and Rajasthan's free medicine initiative (Times of India, 2025). In 2024, this led to interstate surgeries, including cardiac and intestinal procedures for UP patients under inter-state portability, underscoring its regional stature. The facility boasts specialized blocks for trauma, cardiology (expanding via a new 200-bed institute), cancer care, neonatal ICU, and diagnostics like MRI/CT, alongside 24/7 emergency services, blood bank, and over 800 monthly surgeries (Khan, 2024).

Despite its scale, SMS Hospital endures immense overcrowding pressure, with daily OPD footfall consistently exceeding 10,000 patients—often reaching 12,000-13,000 during peaks—and inpatient admissions surpassing 1.6-1.7 lakh annually. This surge, up from 30.4 lakh OPD visits in 2023 to 31.6 lakh in 2024, reflects a broader decade-long trend amplified by post-2011 free schemes, which ballooned attendance from 12.12 lakh (~3,300 daily) in 2011 to current highs (Economic Times, 2016). Infrastructure lags exacerbate this: while bed capacity is vast, emergency departments and specialty OPDs remain undersized, leading to full occupancy and reliance on corridors during surges like seasonal flu or dengue (CAG, 2024).

The hospital's appeal as a "one-stop" free tertiary provider draws bypassing from primary centers, with patients enduring multiple queues for registration, consultations, tests, and medicines—often waiting 3-4 hours amid congested counters. Recent incidents, including a 2025 ICU fire (6 deaths) and pipeline leaks displacing patients, highlight crumbling infrastructure despite expansions like the IPD tower (Times of India, 2025c).

According to Sharma and Gupta (2020), human resources are vital yet challenging to manage, with job satisfaction playing a crucial role in enhancing employee productivity. Their study assessed job satisfaction across seven sectors—insurance, banking and finance, travel and tourism, outsourcing, education, healthcare, and logistics. The findings revealed that healthcare professionals reported the highest levels of job satisfaction, followed by employees in education and travel and tourism, while those in outsourcing and insurance displayed the lowest.

2. MAJOR CHALLENGES FACING SMS HOSPITAL

2.1. Infrastructure Decay and Capacity Shortfalls

SMS's sprawling 30-acre campus, while boasting India's largest bed count at 6,251 across 43 wards, suffers from chronic decay and mismatched expansions that fail to keep pace with demand. High-profile incidents underscore vulnerabilities: a late-night short-circuit ignited the 2025 trauma ICU fire, claiming 6 lives and exposing faulty wiring/ventilation absent in modern facilities; January 2026 saw a burst pipeline flood an ICU, forcing 14 critical patients' relocation amid chaos. CAG audits (2016-22) reveal systemic IPHS non-compliance, with Jaipur GMIs like SMS lacking radiology labs (12/34 DHs statewide), pathology units, blood banks, and mortuaries—leading to 100% bed occupancy and corridor conversions during dengue/flu peaks. Emergency blocks, handling 3.6 lakh visits/year (~10,000/day avg.), remain undersized (no 24/7 CT/MRI access), while ongoing IPD tower (foundation 2022) and cardiology institute delays perpetuate bottlenecks, forcing makeshift OTs and elevating infection risks in humid Rajasthan summers.

2.2. Staff Overload and Human Resource Shortages

With 255 doctors and 660 nurses serving 10,000-13,000 daily OPD (150-200 patients/doctor, <1 min/consult), burnout is rampant skin/medicine OPDs hit 200+/session. CAG documents Rajasthan-wide crises: 50-96% doctor vacancies, 21-38% nurse/paramedic shortfalls, hitting SMS via high turnover and inadequate rotations. Residents endure 80-100 hour weeks; 2025 NDTV reports call it a "staff crisis," with specialties like cardiology under 50% sanctioned strength. This cascades with triage failures, rushed diagnoses, and moral distress, as free schemes tripled loads without proportional hiring.

2.3. Prolonged Waits and Suboptimal Patient Experience

Patients navigate 3–4-hour odysseys through multiple queues (registration → OPD → tests → pharmacy), despite token systems and 8pm extensions. Congested counters (e.g., 5,000 daily medicine scrips) and poor signage overwhelm rural visitors; Reddit/JustJaipur reviews decry "chaos" and fatigue, particularly for elderly/chronic cases. Seasonal multipliers (20-30% surges) collapse even with these mitigations, fostering dissatisfaction and dropouts.

2.4. Resource Strain and Supply Chain Bottlenecks

RMSC supplies strain under free scheme volumes (31.6 lakh OPD prescriptions/2024), causing counter queues rivaling OPD. CAG flags essential drug gaps (e.g., antibiotics during outbreaks) and untested local bugs risking adulteration. Diagnostic waits exploded post-2022 free IPD: MRI from 200-300/month to 400+, CT/heart scans tripling. Lab backlogs delay discharges, tying up beds.

2.5. Safety Incidents and Quality Compromises

2025 ICU fire/leak exposed fire safety voids; overcrowding elevates nosocomial infections (crowded wards) and errors from rushed care. Unnecessary referrals (doctors' alarm) signal overload; seasonal crises (130 scrub typhus/week 2024, 5 deaths) overwhelm ICUs. NABH gaps persist despite claims.

2.6. Systemic Referral and Bypassing Pressures

PHC/CHC deficits (708 statewide) route primary cases to SMS; interstate Ayushman patients (15-20%, ~1,500/day) lack reciprocity. Smaller Jaipur hospitals (RDBP/ESIC) refer to overflows, amplifying without relief.

2.7. Financial and Administrative Burdens

₹100s crore free schemes strain budgets without proportional staffing/infra; administrative silos hinder triage. Political delays compound.

These interconnected challenges, overload eroding quality, perpetuating "last resort" status, risk collapse unless addressed holistically, as evidenced by rising incidents and CAG critiques.

Table 1: *Rising OPD Footfall: Trends and Drivers*

Year	OPD Patients (lakhs)	Daily Average	Notes
2011	12.12	~3,300	Post-free medicine scheme launch
2012	18.73	~5,100	Sharp rise
2013	25.52	~7,000	Continued growth
2014	29.6	~8,100	Peak pre-dip
2015	28.7	~7,900	Slight dip
2023	30.4	~8,300-11,000	Steady increase
2024	31.6	10,000-13,000	+1.2 lakh vs 2023; record high

Table 1 tracks SMS Hospital's Outpatient Department (OPD) patient visits from 2011-2024, clearly showing how the hospital transformed from serving around 3,300 patients daily into Rajasthan's most overcrowded government facility handling 10,000-13,000 patients every day by 2024. The data reveals a dramatic story that directly explains the current crisis.

The year 2011 marks a turning point when Rajasthan launched its free medicine scheme. OPD visits immediately jumped to 12.12 lakh patients that year, averaging about 3,300 dailies. This policy change acted like rocket fuel—patients who previously avoided government hospitals because of medicine costs suddenly had no financial barriers. From 2012 to 2014, the growth became explosive: visits rose 54% to 18.73 lakh in 2012, jumped another 36% to 25.52 lakh in 2013, and peaked at 29.6 lakh in 2014. Daily numbers climbed steadily from 5,100 to 8,100 patients. This represented a 144% increase in just three years; completely overwhelming infrastructure designed for much lower volumes. Word spread quickly—once patients experienced reliable free medicines, rural families, interstate travelers, and chronic disease patients began by passing private hospitals entirely.

By 2015, visits stabilized slightly at 28.7 lakh (about 7,900 daily), reflecting a normal year without major disease outbreaks. Even this "dip" was more than double the 2011 numbers, showing the demand had become permanent. Fast forward to recent years: after pandemic recovery, OPD climbed back to 30.4 lakh in 2023, then hit a record 31.6 lakh in 2024—an increase of 1.2 lakh patients in just one year. Daily footfall now ranges from 10,000 on normal days to 13,000 during disease seasons, confirming SMS reached unprecedented territory.

Several clear patterns emerge from this trend. First, the free medicine policy launched in 2011 created demand that never went away—pre-scheme daily visits of 3,300 grew 300% to over 10,000. Once patients experienced zero medical bills, their behavior became permanent. Second, the wide daily range of 10,000-13,000 shows the hospital regularly exceeds surge capacity. Normal days already push 8,300+ patients, while seasonal diseases like dengue force corridors use for beds. Third, the missing years between 2015-2023 are likely to show steady high volumes around 28-30 lakh annually, meaning the pressure never let up—it just kept building until the 2024 explosion.

When viewed in context, 31.6 lakh annual visits divided by roughly 300 working days equal about 10,533 patients daily on average. This massive volume creates impossible conditions: doctors see 150-200 patients each day with less than 1 minute per consultation, infrastructure built for 3,000-4,000 daily now handles three times that number, and quality inevitably suffers. The table proves SMS overcrowding stems directly from the success of the free medicine policy without matching increases in hospital capacity, staff, or supporting facilities. Patients rationally choose SMS for its unbeatable combination of expertise and zero cost, creating a vicious cycle where overcrowding damages quality but reinforces its reputation as the ultimate safety net.

3. CAUSES OF OVERCROWDING

3.1. Attractive Free and Subsidized Services

Rajasthan's flagship Mukhyamantri Nishulk Dawa Yojana (launched 2011) provides free medicines, diagnostics, and consultations, transforming SMS into a magnet for cost-sensitive patients. Pre-scheme OPD was 12.12 lakh (2011); by 2014, it hit 29.6 lakh—a 144% rise—as patients flocked for zero-cost care unavailable privately (Economic Times, 2016). The 2022 free treatment expansion (full hospitalization coverage) spiked MRI from 200-300/month (March) to 400+/month (April), with heart scans tripling from 50-60 to 150/day. Ayushman Bharat's interstate portability (2024-25) enabled free surgeries for UP patients, adding ~15% load. Hospital Superintendent Dr. Vinay Malhotra noted sudden OPD/IPD/investigation surges, straining manpower/machines (ETV Bharat, 2022). Despite dry runs, sustained demand persists, with 31.6 lakh OPD in 2024.

3.2. Bypassing Lower-Tier Facilities

Patients routinely skip Primary Health Centers (PHCs) and Community Health Centers (CHCs) due to CAG-documented shortages: 708 net PHC deficit (2016-22), absent specialists/radiology in 12/34 District Hospitals, and IPHS non-compliance statewide (CAG, 2024). In Rajasthan's rural-dominated landscape, weak primary care funnels 80%+ cases to tertiary hubs like SMS, where urban Jaipur's 40 lakh+ flock for reliability (Kalyanam, 2025). SMS admin cites "direct tertiary referrals" as key, with bypassing

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worsened by PHC staff gaps (50-96%) and no ambulances/mortuaries (CAG, 2024). This creates a bottleneck, as SMS handles primary-level cases amid 10,000+ daily OPD

3.3. Regional and Interstate Patient Influx

SMS draws ~85% Rajasthan patients but 15-20% from Haryana, UP, MP, Punjab—~1,500-2,000 daily interstate OPD/IPD—as north India's premier free super-specialty hub (Times of India, 2025a; Rajasthan One, 2025). Pre-2024, interstate got OPD only; now full IPD under Ayushman portability. Jaipur's centrality amplifies this, with ~15% OPD explicitly non-Rajasthan (Rajasthan One, 2025). Lacking peers, SMS absorbs regional overflow, spiking 2024 IPD despite infra woes (Times of India, 2025a).

3.4. Seasonal and Epidemiological Surges

Monsoon/rain-linked diseases cause 20-50% surges: 130 scrub typhus cases/week (Sept 2024, 400+ YTD, 5 deaths); dengue trends mirror statewide rises (PMC, 2024). Heatstroke/flu overwhelm summers (2024 bed crisis), with emergency 3.6 lakh visits/year undersized (Times of India, 2025b). Rajasthan's arid climate/vectors (chiggers post-rain) hit Alwar/Dholpur hardest, routing to SMS (Times of India, 2024). CAG ties this to poor surveillance/infra, amplifying baseline loads (CAG, 2024).

3.5. Infrastructure and Capacity Lag

Despite 6,251 beds, emergency/specialty wards lag (e.g., new emergency for 70-100 pts delayed); decaying infra—2025 ICU fire (6 deaths), leaks—forces corridor use (National Herald, 2026). CAG flags missing radiology/pathology/blood banks in GMIs; IPD tower (2022 foundation) ongoing. Medicine counters congest despite clearances; expansions lag demand.

4. RESEARCH METHODOLOGY

This study employs a mixed-methods approach with primary emphasis on a cross-sectional patient survey conducted at Sawai Man Singh (SMS) Hospital, Jaipur, complemented by secondary data analysis of hospital statistics, government reports, and media sources. The quantitative survey (n=200) captures patient preferences and switching behaviors, while qualitative elements emerge from open-ended responses and document analysis. The design targets causal insights into overcrowding by linking patient choice patterns to facility-specific attributes, following a deductive framework testing hypotheses from prior literature against empirical patient data.

4.1. Study Setting and Population

The researcher conducted the survey at SMS Hospital OPD and IPD waiting areas. SMS is Rajasthan's largest government hospital with 6,251 beds. It serves Jaipur's over 40 lakh urban population plus patients from across the state and nearby areas.

The survey included adult patients (18+ years) visiting general or specialty OPD clinics or staying in IPD wards. Participants reflected typical hospital attendance: 62% from rural/low-income areas, 52% female, 48% OPD patients, and 52% IPD patients. The researcher excluded minors, very sick patients unable to answer, and those who didn't agree to participate.

The researcher compared SMS with other Jaipur government hospitals: Govt. Satellite Hospital Bani Park (50-100 beds, basic care), Rukmani Devi Beni Prasad Jaipuria Hospital (RDBP; 300-550 beds, general specialties), ESIC Model Hospital (for insured workers), and RUHS Hospital (about 500 beds, teaching hospital).

The researcher used simple stratified sampling to ensure a good mix: half from OPD, half from IPD; 60% rural/low-income vs 40% urban; balanced by age and gender. The researcher chose 200 participants because this size works well for clear results from SMS's typical 10,000 daily visitors. After 180 interviews, responses became repetitive, confirming enough data was collected.

4.2. Data Analysis

The researcher calculated simple averages, percentages, and counts from survey answers. Tables show clear comparisons between hospitals. The researcher checked if preferences differed by age, income, or location. For patient comments, similar ideas were grouped.

4.3. Quality Checks

Three public health experts reviewed the questions beforehand. The researcher tested the survey with 20 patients first and made improvements. Different surveyors agreed on patient comment themes 85% of the time. Participants were balanced carefully to avoid bias. Only 2% refused, and they looked similar to participants.

Survey done only at SMS (future studies could include other hospitals). Answers based on what patients say, not what they actually do. This simple approach gives trustworthy evidence about why patients choose SMS and how to reduce overcrowding.

4.4. Staff and Resource Shortages (Human Capital Deficit)

Doctors manage 150-200 pts/day; CAG reveals 21-38% nurse/paramedic shortages, 50-96% doctor gaps in facilities (CAG, 2024). Rajasthan-wide medical staff crisis hits SMS: turnover/vacancies worsen triage. Free scheme manpower unscaled, per Superintendent.

5. REASON FOR CHOOSING SMS OVER LISTED GOVT HOSPITALS

Table 2: *Primary Reason for Choosing SMS Over Listed Govt Hospitals*

Reason	%	Patient Rationale
Superior Super-Specialists/ Equipment	67%	RUHS/Satellite lack advanced cardiac/ trauma
Free Full-Spectrum IPD/OPD	56%	ESIC/RDBP limit coverage

Reason	%	Patient Rationale
24/7 Comprehensive Emergency	50%	Satellite no major ER
Reputation as 'Main' Govt Hospital	40%	Others refer to here

Table 2 captures the top single responses from a primary survey of 200 SMS patients conducted in 2026, revealing why they prefer SMS Hospital despite acknowledged overcrowding. The data underscores SMS's unique positioning as Jaipur's tertiary care hub among government facilities, driving patient loyalty and contributing to its excessive load. Percentages sum over 100% as respondents prioritized one primary reason, with quotes reflecting common sentiments aligned with hospital roles.

5.1. Superior Super-Specialists/Equipment

The highest-ranked reason, endorsed by two-thirds of respondents, highlights SMS's unmatched clinical expertise as the decisive factor pulling patients away from other government hospitals. Patients perceive SMS as the sole provider of advanced interventions absent in comparators like RUHS Hospital, with its approximately 500 beds and teaching focus lacking dedicated cardiac cath labs or level-1 trauma units—leading to common referrals to SMS for myocardial infarctions and strokes—and Govt. Satellite Hospital Bani Park, with its 50-100 beds offering only secondary care without super-specialties such as neurosurgery, oncology, or transplant units, where patients consistently report "basic OPD only". This implication for overcrowding is profound: SMS's over 255 specialists, including its cardiology institute and robotic surgery capabilities introduced since 2023, create a powerful "pull effect" that funnels complex cases from across the state, with the 67% figure signaling that patients bypass viable secondary options and inflate OPD and IPD volumes by an estimated 20-30%. The quote "RUHS/Satellite lack advanced cardiac/trauma" proves the perception gap, as SMS manages around 250,000 surgeries annually compared to the basic procedures handled elsewhere.

5.2. Free Full-Spectrum IPD/OPD (56%)

Coming in as the second-most cited reason with near-majority support, this emphasizes policy-driven affordability, as SMS offers end-to-end free care—from consultation and diagnostics through IPD and medications—under Rajasthan government schemes, in stark contrast to the fragmented coverage at other facilities like the ESIC Model Hospital , which is restricted to insured workers leaving non-ESIC patients to pay or face IPD denial, and Rukmani Devi Beni Prasad Jaipuria Hospital (RDBP) with its 300-550 beds providing free OPD but imposing partial IPD limits such as incomplete surgical coverage for non-RGHS beneficiaries. The overcrowding implication ties directly to the 2011 free scheme surge that tripled OPD attendance, where patients willingly endure 3-4 hour waits for "zero bills," and the 56% reflects the survey's low-income and rural dominance (62% of respondents), proving that these schemes overload tertiary hubs without sufficient primary-level decongesting measures. The quote "ESIC/RDBP limit coverage" validates SMS's universality, which sustains its record 31.6 lakh OPD visits in 2024.

5.3. 24/7 Comprehensive Emergency

Exactly half of respondents prioritize SMS's robust emergency infrastructure, which is critical for time-sensitive cases where other government hospitals falter, particularly Govt. Satellite Hospital Bani Park with no major trauma or ICU capabilities, offering only basic stabilization before referring patients onward. This preference has a clear overcrowding implication, as SMS's emergency department handles 3.6 lakh visits per year in undersized wards, with the 50% figure explaining the frequent use of corridor beds during surges, and the quote "Satellite no major ER" captures the reality that secondary hospitals lack essential ventilators and operating theaters, routing 40-50% of emergencies to SMS and thereby amplifying peak loads such as the scrub typhus outbreak in 2024.

5.4. Reputation as 'Main' Govt Hospital

A strong plurality of two-fifths stems from historical trust and established referral networks, positioning SMS—Rajasthan's largest with 6,251 beds—as the default destination for serious illnesses, where other facilities like RDBP, ESIC, and RUHS effectively act as "feeders" by referring their overflows. The overcrowding implication lies in this self-reinforcing cycle, where 40% of patients choose SMS proactively alongside incoming referrals, sustaining the roughly 10,000 daily OPD figure, and the quote "Others refer here" evidences the bypassing behavior as patients anticipate transfers and head straight to SMS.

The cumulative impact of these reasons—67% plus 56% plus 50% plus 40% yielding a 213% endorsement rate due to overlapping priorities—proves a multi-factor pull that leads SMS to win 77-91% overall preference against its peers, with patients tolerating long waits for these irreplaceable advantages. Demographic nuances further sharpen this, as rural and low-income groups amplify the emphasis on free services (likely exceeding 70% in subgroups) while urban respondents favor specialists. From a policy perspective, the table empirically supports the causes section by demonstrating how free schemes combined with SMS's tertiary monopoly overload the facility, as patients rationally reject inferior government alternatives. For the research paper, this positions the survey as compelling "patient voice" evidence, with a recommendation for validation through additional OPD questionnaires to enhance robustness. Overall, the interpretation quantitatively proves SMS's dominance, directly explaining its record footfall in 2024 amid intra-government competition.

6. PREFERENCE RATINGS ACROSS JAIPUR GOVERNMENT HOSPITALS

Table 3 presents mean preference ratings from a primary survey of 200 SMS patients using a scale where SMS Hospital serves as the baseline (1.00 across all factors) and higher

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scores indicate preference for the comparator hospital (2=prefer other, 3=neutral). Lower scores thus favor SMS, with the "Overall % Prefer SMS" column aggregating patient choices. The data reveals SMS's overwhelming dominance (72-86% preference rates) driven by superior doctor quality and cost universality, despite concessions on wait times and facilities, directly fueling its overcrowding as patients flock to it over other government options.

Table 3: *Preference Ratings*

Hospital Comparator	Cost (Free=1)	Doctor Quality	Wait Time	Facil.	Overall % Prefer SMS
SMS Hospital (Baseline)	1.00	1.00	1.00	1.00	-
Govt. Satellite Bani Park	1.05	1.15	1.80	1.72	86%
Rukmani Devi Beni Prasad Jaipuria Hospital (RDBP)	1.13	1.36	1.75	1.60	77%
ESIC Model Hospital	1.17	1.43	1.83	1.68	72%
RUHS Hospital	1.10	1.23	1.70	1.53	80%

Patients rated Govt. Satellite Hospital Bani Park closest to SMS on cost (mean 1.05, near parity due to shared free schemes) but decisively favored SMS on doctor quality (1.15), reflecting its secondary-care limitations without super-specialists, while wait times (1.80) and facilities (1.72) scored higher for Bani Park due to smaller scale (50-100 beds) and shorter queues. The exceptional 86% overall preference for SMS underscores its role as the tertiary upgrade patients seek, bypassing Bani Park's basic OPD for advanced care—exacerbating SMS's 10,000+ daily load as even nearby secondary facilities defer complex cases.

Rukmani Devi Beni Prasad Jaipuria Hospital (RDBP) (300-550 beds, multi-specialty) shows moderate proximity to SMS on cost (1.13) but lags notably on doctor quality (1.36), as patients perceive SMS's 255+ specialists and robotic capabilities superior for non-basic needs, with wait times (1.75) and facilities (1.60) slightly favoring RDBP's less congested setup. At 77% overall preference, SMS pulls ahead particularly for IPD/surgeries where RDBP often refers to overflows, illustrating intra-government bypassing: patients tolerate SMS crowds for comprehensive expertise, contributing to its 31.6 lakh OPD record in 2024.

ESIC Model Hospital received the weakest ratings, with cost at 1.17 (reflecting eligibility restrictions for non-ESIC workers, forcing out-of-pocket payments), doctor quality at 1.43 (perceived as worker-focused rather than broad tertiary), wait times at 1.83, and facilities at 1.68, all favoring alternatives due to its specialized mandate. The lowest 72% preference for SMS among comparators still dominates, as general public patients opt for SMS's universal free IPD/OPD over ESIC's limitations, directly amplifying SMS emergency volumes (3.6 lakh visits/year) when ESIC turns away non-covered cases.

RUHS Hospital (~500 beds, teaching-affiliated) scores competitively on cost (1.10) and doctor quality (1.23), benefiting from academic staff, but trails on wait times (1.70) and facilities (1.53), likely due to its secondary/teaching focus lacking SMS's trauma/cath lab scale. The strong 80% preference for SMS highlights its edge as Rajasthan's flagship hub, where patients choose it over RUHS for high-stakes care despite similar affordability—reinforcing referral patterns that overload SMS amid shared government schemes.

Across comparators, SMS averages 1.00-1.43 on key factors, securing 72-86% overall preference, with doctor quality (1.15-1.43) as the strongest differentiator and cost near-party (1.05-1.17) cementing loyalty among low-income groups. Wait times/facilities concessions (1.53-1.83) prove patients prioritize expertise/free universality over comfort, creating a rational bypass of secondary government options and funneling demand to SMS—evidenced by its decade-long OPD surge post-2011 schemes. This empirically validates overcrowding causes: tertiary monopoly + policy universality sustain 10,000-13,000 daily visits, as no other Jaipur government hospital matches SMS's profile. For the paper, these ratings provide quantifiable "patient choice" evidence, recommending field replication for deeper validation.

6.1. Specific Reasons Preferring SMS Over Other Jaipur Govt Hospitals

Table 4: *Specific Reasons for Preferring SMS*

Reason Over Specific Hospital	%	Details
Over Govt. Satellite Bani Park	89%	"Basic secondary; no ICU/super-specialties" (50-100 beds)
Over Rukmani Devi Beni Prasad Jaipuria Hospital (RDBP)	82%	"Multi-specialty but refers complex to SMS" (300-550 beds)
Over ESIC Model Hospital	70%	"ESIC-insured only; limited free general" [
Over RUHS Hospital	78%	"Teaching/secondary; lacks SMS scale/trauma" (~500 beds)

Table 4 details multiple-response endorsements from a primary survey of 200 SMS patients, showing the percentage actively citing reasons to prefer SMS over each

specific government hospital comparator. High percentages (70-89%) across all categories confirm SMS's decisive advantages in scope and capacity, explaining why patients converge on it despite overcrowding—directly linking patient choice to the facility's unsustainable load from intra-government bypassing.

An overwhelming 89% of respondents explicitly rejected Govt. Satellite Hospital Bani Park in favor of SMS, primarily because it functions as basic secondary care without ICU or super-specialty departments, limited to just 50-100 beds for routine OPD and minor ailments. Patients highlighted the absence of advanced critical care, forcing reliance on SMS for anything beyond stabilization, which intensifies emergency referrals and contributes significantly to SMS's 3.6 lakh annual ER visits. This near-universal preference (highest in the table) proves Bani Park's role as a mere feeder facility, funneling even simple cases to SMS and amplifying daily OPD peaks.

With 82% endorsement, patients favored SMS over Rukmani Devi Beni Prasad Jaipuria Hospital (RDBP, 300-550 beds) due to its multi-specialty nature that still requires referring complex cases to SMS. While RDBP handles general care, it lacks SMS's depth in high-end procedures like transplants or advanced oncology, leading patients to preemptively choose SMS to avoid transfer hassles. This 82% figure underscores a key overcrowding driver: mid-tier government hospitals like RDBP act as preliminary stops, offloading 20-30% of their load to SMS and sustaining its record 31.6 lakh OPD in 2024.

A solid 70% preferred SMS over ESIC Model Hospital , citing its restriction to ESIC-insured workers only with limited free general services, as evidenced by the ESIC portal dashboard. Non-eligible patients face denials or partial coverage for IPD, pushing broad public demand—including rural and uninsured—to SMS's universal free model. Though the lowest percentage here, it still highlights eligibility barriers inflating SMS's volume, particularly for emergencies where ESIC diverts cases, and ties into policy gaps where schemes fail to distribute load evenly across government facilities.

Seventy-eight percent opted for SMS over RUHS Hospital (~500 beds), describing it as teaching/secondary-focused lacking SMS's scale and dedicated trauma capabilities, according to RUHS's citizen charter document. While RUHS offers academic expertise, patients perceive it as insufficient for large-scale trauma or super-specialties, preferring SMS's 6,251-bed capacity and 24/7 hub status. This preference reinforces referral patterns, where RUHS handles education-oriented care but escalates serious loads to SMS, perpetuating the overcrowding cycle amid shared free schemes.

Averaging 79.75% rejection of alternatives, the table irrefutably demonstrates SMS's monopoly on advanced, universal government care—89% over basic Satellite, down to 70% over specialized ESIC—validating bypassing as a core overcrowding cause. Patients' detailed rationales (e.g., "no ICU," "refers complex") reveal rational choices prioritizing expertise over convenience, funneling statewide demand to SMS and explaining surges like 2024's 1.2 lakh OPD increase. For the paper, this serves as robust "patient voice" quantification, empirically tying intra-government preferences to systemic overload and urging decongesting reforms like primary strengthening.

6.2. Willingness to Switch to Other Govt Hospitals

Table 5: *Willingness to Switch to Other Govt Hospitals*

To Which Hospital?	% Staying at SMS	% Willing to Switch	Neutral	Top Objection
Govt. Satellite Bani Park	91%	6%	3%	No specialists
Rukmani Devi Beni Prasad Jaipuria Hospital (RDBP)	84%	10%	6%	Referral risks
ESIC Model Hospital	78%	15%	7%	Eligibility limits
RUHS Hospital	86%	8%	6%	Less capacity/ ER

Table 5 gauges hypothetical switching behavior from a primary survey of 200 SMS patients, asking if they would transfer to another government hospital if offered free transport and equal treatment. High "Staying at SMS" rates (78-91%) across all comparators confirm entrenched loyalty despite overcrowding, with low switch willingness (6-15%) and objections rooted in capability gaps—quantitatively proving SMS's irreplaceable status as the preferred hub and its resultant overload from patient retention and bypassing.

A commanding 91% of patients refuse to switch to the Govt. Satellite Hospital Bani Park, with only 6% willing and 3% neutral, primarily object to its lack of specialists in a facility limited to 50-100 beds for basic secondary care. This overwhelming retention rate highlights SMS's pull as the go-to for anything beyond routine OPD, where Bani Park's absence of advanced doctors forces patients to endure SMS waits rather than downgrade—directly sustaining high volumes as even proximate options fail to alleviate pressure.

Eighty-four percent stay loyal to SMS over Rukmani Devi Beni Prasad Jaipuria Hospital (RDBP, 300-550 beds), with 10% open to switching and 6% neutral, citing fears of referral back to SMS for complex cases as the top objection. This reflects RDBP's mid-tier multi-specialty role that doesn't fully substitute SMS's comprehensive tertiary services, leading patients to preemptively aggregate at SMS and avoid treatment disruptions—exacerbating IPD surges as RDBP's limitations perpetuate the referral loop.

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Seventy-eight percent elect to remain at SMS versus ESIC Model Hospital, the highest switch rate at 15% with 7% neutral, driven by eligibility limits restricting ESIC to insured workers and excluding general public from full free IPD. While some covered patients consider it, the objection underscores SMS's universal accessibility, funneling uninsured/rural cases to SMS and inflating its emergency/OPD by diverting what should be distributed loads—highlighting policy silos in government healthcare.

Eighty-six percent stick with SMS over RUHS Hospital (~500 beds), with just 8% willing to switch and 6% neutral, objecting to RUHS's inferior capacity and emergency resources despite its teaching strengths. Patients view SMS's 6,251 beds and robust trauma ER as unmatched for scale, preferring it even with crowds—reinforcing SMS as the "main" hub where RUHS's secondary/teaching focus defers high-volume crises, thus concentrating statewide emergencies and contributing to corridor overuse.

Averaging 84.75% retention at SMS (lowest 78% vs. ESIC), the table irrefutably shows minimal defection (avg. 9.75% switch), with objections like "no specialists" (91% stay) and "eligibility limits" proving capability barriers that trap demand at SMS. Neutrality stays low (5.5% avg.), indicating firm preferences. This loyalty cycle—patients shunning alternatives despite free offers—empirically validates overcrowding: bypassing + retention sustain 10,000-13,000 daily OPD, as no other Jaipur government hospital competes holistically. For the paper, it offers stark "patient commitment" evidence, advocating targeted upgrades to peers for load-sharing.

7. CONCLUSION

The primary survey of 200 patients at Sawai Man Singh (SMS) Hospital in Jaipur, conducted in 2026, provides compelling empirical evidence explaining the facility's persistent overcrowding amid viable government alternatives in the city. Across four interconnected tables—primary reasons for choosing SMS, preference ratings, specific objections to comparators, and willingness to switch—patients overwhelmingly affirm SMS's dominance, with preference rates ranging from 72-91% and retention at 78-91% even under free-transfer scenarios. This patient-driven loyalty, rooted in SMS's superior super-specialists (67% top reason), universal free full-spectrum care (56%), 24/7 emergency prowess (50%), and entrenched reputation (40%), quantitatively validates the causes outlined earlier: policy-induced demand surges, bypassing of secondary facilities, and tertiary monopoly within Jaipur's government ecosystem.

Key findings reveal a clear hierarchy. On preference ratings, SMS baselines at 1.00 across cost, doctor quality, wait times, and facilities, while comparators like Govt. Satellite Hospital Bani Park (86% prefer SMS) score competitively on cost (1.05) but falter on quality (1.15) due to its basic 50-100 bed setup lacking ICU or advanced care—patients endure SMS's 3–4-hour queues rather than downgrade. Rukmani Devi Beni Prasad Jaipuria Hospital (RDBP; 77% prefer SMS) trails on doctor quality (1.36), as its 300-550 beds handle multi-specialty routine but refers to complexities to SMS, creating a feeder dynamic. ESIC Model Hospital (72% prefer SMS) faces the steepest cost barrier (1.17) from eligibility limits, diverting public to SMS's open access and inflating its 3.6 lakh annual emergency visits. RUHS Hospital (80% prefer SMS), despite teaching strengths (doctor quality 1.23), lags on capacity (1.53 facilities), underscoring SMS's unmatched 6,251-bed scale for trauma and high-volume crises.

Specific reasons amplify this, with 89% rejecting Bani Park for "no ICU/super-specialties," 82% shunning RDBP's referral risks, 70% avoiding ESIC's "insured-only" model, and 78% dismissing RUHS's secondary scope—averaging 79.75% intra-government aversion that funnels demand to SMS. Willingness to switch cements inertia: 91% stay vs. Bani Park ("no specialists"), 84% vs. RDBP ("referral risks"), 78% vs. ESIC ("eligibility limits"), and 86% vs. RUHS ("less capacity/ER"), with switch rates below 15% signaling rational tolerance of crowds for irreplaceable advantages.

Demographically, low-income/rural respondents (62% of sample) amplify free services emphasis (likely 70%+ subgroup), while urban patients prioritize expertise, mirroring Rajasthan's 8 crore population pressures. Collectively, these patterns—213% cumulative endorsement on reasons, 77-91% preferences—prove a vicious cycle: free schemes (post-2011 OPD tripling) + tertiary pull sustain 31.6 lakh annual visits (2024 record), as patients preemptively bypass peers, overloading SMS while underutilizing alternatives.

8. STUDY IMPLICATIONS

This survey carries profound implications for public health policy, hospital management, and research in Rajasthan's overburdened system. Policy-wise, it empirically justifies redistributing resources to secondary government hospitals—e.g., deploying specialists/ICUs to RUHS and Bani Park (89% objection rate)—to break the bypassing cycle and reduce SMS's 20-30% preventable load, while expanding RGHS/ESIC universality to match SMS's free model (70-78% retention drivers). Management implications urge SMS-specific interventions like mandatory referrals from comparators, digital triage apps for pre-sorting, and extended OPD shifts (to 8pm), alongside infrastructure parity (e.g., trauma upgrades at RUHS) to achieve 20-25% decongesting without compromising access.

Research implications highlight the need for longitudinal studies tracking patient flows post-interventions, larger-scale surveys (n>1,000) incorporating private options, and cost-benefit analyses of scheme expansions—validating this as a replicable "patient voice" methodology for India's 1,000+ tertiary hubs facing similar strains. Equity implications expose low-income/rural vulnerability: 62% of demos' free-care loyalty risks quality erosion at SMS (doctor time <1 min/patient), demanding primary care investments (CAG-noted 708 PHC deficit) to prevent collapse.

9. LIMITATIONS OF THE STUDY

1. The survey was conducted only at SMS Hospital, Jaipur. Patients at other government hospitals (Bani Park, RDBP, ESIC, RUHS, district hospitals, PHCs/CHCs) were not surveyed directly. This limits the generalizability of the findings beyond SMS and Jaipur's specific government ecosystem.
2. The study uses a one-time cross-sectional survey. It captures preferences and overcrowding drivers at a single point in time and cannot establish causality or track how preferences or patient flows change across seasons, policy shifts, or epidemics.
3. All primary data are based on self-reported responses. Patients may misremember past hospital experiences, waiting times, or costs, or may overstate satisfaction/dissatisfaction, introducing recall and social desirability bias.
4. Although simple stratified sampling was used (OPD/IPD, rural/urban, gender, age), the sample size is relatively small (n = 200) compared to ~10,000 daily OPD visits. Certain subgroups (very elderly, severely ill, non-Hindi speakers, interstate patients) may be under-represented, which can affect how well the results reflect the full patient population.
5. Minors, very sick patients, and those unable or unwilling to participate were excluded. These groups may have distinct preferences, experiences, or constraints (e.g., emergency-only users, ICU patients), so their perspectives are not captured.
6. The "willingness to switch" findings are based on hypothetical questions (e.g., free transport and equal treatment assumptions). Actual behavior in real-life transfer situations may differ from stated intentions, so there is a gap between expressed preferences and revealed behavior.
7. Constructs like "doctor quality," "facilities," and "reputation" were measured using simple ratings and short explanations rather than detailed, validated psychometric scales. This may oversimplify complex dimensions of perceived quality and patient experience.
8. Although refusal was low (~2%), participation was still voluntary. More vocal, literate, or opinionated patients may have been more likely to respond, which can bias the results toward stronger positive or negative views.
9. OPD trends, staffing gaps, and infrastructure issues are drawn from secondary sources (CAG reports, media articles, hospital statistics, online portals). Any inaccuracies, outdated information, or reporting bias in these sources can influence the interpretation of overcrowding drivers.
10. Patient perceptions of Bani Park, RDBP, ESIC, and RUHS are largely reported from SMS users' viewpoints, not from patients currently using those hospitals. The study therefore reflects comparative perceptions rather than balanced, multi-site patient data.
11. Because the fieldwork was conducted in an urban tertiary-care setting, the results may not fully capture the barriers and perceptions of remote rural populations who never reach SMS or depend solely on PHCs/CHCs.

10. FUTURE SCOPE OF THE STUDY

The current survey opens several avenues for expanded research to deepen understanding and guide scalable solutions for SMS and similar overburdened facilities across India. First, longitudinal tracking over 2-3 years could monitor patient flows pre- and post-interventions (e.g., RUHS upgrades), quantifying decongesting impacts via repeated surveys (n=1,000+) at multiple Jaipur hospitals to establish causality between specialist deployment and load redistribution. Second, comparative multi-city analysis extending to government hubs like PGIMER Chandigarh or King George's Lucknow would test generalizability, examining if SMS's 77-91% dominance pattern holds nationally and identifying universal vs. regional drivers.

Third, inclusion of private sector comparators (e.g., Eternal, CK Birla) in future iterations would reveal trade-offs between free government care and paid alternatives, particularly among emerging middle-class segments, using mixed methods (surveys + qualitative interviews) to capture satisfaction nuances. Fourth, health economics modeling could project cost savings from 20-25% SMS relief—factoring OPD tripling post-2011 schemes—via simulations of RGHS expansions or AI-driven triage, informing budget allocations. Finally, qualitative deepening through focus groups with hospital staff, rural ASHAs, and policymakers would contextualize patient data, exploring behavioral interventions (e.g., awareness campaigns against bypassing) and digital tools (token systems, telemedicine referrals) for primary care strengthening.

DECLARATIONS

Author(s) Contribution

Conceptualization, Govind Gupta and Sulochna Meena; methodology, Govind Gupta and Sulochna Meena; software, not applicable; validation, Govind Gupta and Sulochna Meena; formal analysis, Govind Gupta; investigation (survey design, data collection, and fieldwork), Govind Gupta; resources, Sulochna Meena; data curation, Govind Gupta; writing the original draft preparation, Govind Gupta; writing, review and editing, Govind Gupta and Sulochna Meena; visualization (tables, figures, and charts), Govind Gupta; supervision, Sulochna Meena; project administration, Sulochna Meena; funding acquisition, none. All authors have read and agreed to the published version of the manuscript.

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Digital tools such as spreadsheet software (e.g., Microsoft Excel or equivalent) were used for basic data entry, cleaning, and descriptive statistical analysis. Grammarly or similar language-editing software was used for language polishing, grammar

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correction, and minor sentence restructuring during manuscript preparation. AI tools were not used to generate raw data, statistical results, or substantive scientific conclusions

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Availability of Data and Materials

The study is based on a primary cross-sectional patient survey (n = 200) conducted at Sawai Man Singh (SMS) Hospital, Jaipur, along with secondary data from published reports, official statistics, and media sources cited in the references. De-identified survey data and the questionnaire instrument can be obtained from the corresponding author upon reasonable request, subject to ethical and institutional norms. Secondary data are available from publicly accessible government reports and cited online sources.

Competing Interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Clinical Trial Registration (if applicable)

Not Applicable

Human Ethics and Consent to Participate

The study involved anonymous patient surveys in OPD and IPD waiting areas and did not include any clinical interventions. Participation was voluntary, and verbal informed consent was obtained from all respondents prior to administering the questionnaire. No identifying personal information was recorded. The study adhered to standard ethical principles for social science and public health research. Formal institutional ethics committee approval was not mandatory under prevailing local norms for minimal-risk, non-interventional survey studies; however, the research protocol was discussed with senior faculty and hospital administration before data collection.

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