CHAPTER - I

INTRODUCTION
1.1 INTRODUCTION

The word ‘hospital’ is closely related to the word ‘hospitality’. It is derived from the word ‘hospice’ which means a place of refuge, a house for rest. The hospital is an integral part of any socio-medical organization. The function of hospital is to provide for the population complete healthcare, both curative and preventive, and whose outpatient services reach out to the family and its home environment. The definition of health is not ‘mere absence of disease’ but a positive concept of physical, mental and social well-being (Park, 2002). It has enlarged the scope of activity of hospitals/healthcare centres as they are to be the hub of all such activities for the well-being of an individual in particular and the community in general. The ultimate performance and progress of any civilized society depends upon the state of health of its citizens. The scope of health services varies widely from country to country and influenced by general and ever changing national, state and local health problems, needs and attitudes as well as the available resources to provide these services (WHO Expert Committee, 1961).

Healthcare in India constitutes a basic right and not a commodity. Healthcare is one of the basic services as it is an essential indicator of human development that has been under state control from 1947 onwards. The Bhore Committee formulated in 1948, presented a very useful community-based health programme for India which looked after the well-being of commoners and the facility to be controlled by the state. Keeping in mind India’s rural masses for whom primary healthcare was a necessity, it developed an integrated approach covering the interiors through primary health centres with sub-centres maintaining hierarchy. The state-owned responsibility of providing healthcare facilities emerging from Bhore Committee report was operationalised in the course of the Five-Year Plans. There was enthusiasm in building a new disease-free India where the common people of the lower strata of the society would be concentrated and better looked after.
Committees were set up to bring new changes where the very approach was people-friendly. Since the 90's, a set of reforms emerged in quite a few social sectors in which healthcare also featured. Reforms drastically reduced the state's responsibility for financing and managing the health sector. The state made a silent withdrawal where it had a big role to play. A disparity was created regarding the distribution of facilities. This gap was covered or rather filled by private sector hospitals and nursing homes. It was rather encouraging for the private sector to fill the vacuum created by the state. The state government play a major role in promoting and regulating the general and speciality hospitals in private sector by reserving an agreed proportion of the proposed capacity for the treatment of the poor at a concessional rate. (De, 2007).

Health services in any country should be comprehensive, accessible, acceptable to provide scope for community participation and to make it available at a cost the community and the country can afford (Central Health Education Bureau, 1965) Healthcare was treated as a commodity controlled by market forces. The poor, totally dependent on public facilities also became clients of private health centres. The reason being that they do not wish to lose precious wages in running around public hospitals and wasting time waiting in long queues or being subjected to the multi-window system (technical formalities one has to go through in a public hospital). According to the 52nd round of the National Sample Survey Organization, there has been more than 30 per cent decline in the number of patients seeking care in public health institutions. Patient satisfaction survey in public hospitals shows that corruption has been the main cause of such steep decline along with other causes like poor utilities of water supply and sanitation, lack of cleanliness, poor interpersonal communication skill, and moreover the time spent by them (Mohapatra, 2007).

Hospitals play an important role towards the health and well-being of people of any country. Unfortunately, over the decades, problems including overcrowding, lack of ethical standards, absence of sound management as well as absence of hospitals with human face have created a situation where hospitals have become a sorry proposition for common people. On the whole hospitals run under the Government sector have gone through a sure process of decay where sometimes yesterday's reputed government hospitals can even shock sensitive individuals. The
reasons for such state of affairs are many but the ultimate sufferers are the patients who have no other place to go. The Voluntary Health Association of India (VHAI's) overall interest in healthcare is on preventive and primary healthcare. The growing crisis of the secondary and tertiary care has made us concerned. Keeping this in mind and in view of the need for quality care in public hospitals of Orissa, the researcher tries to find out ways and means of improvement in the management of healthcare.

1.2 DEMOGRAPHIC PROFILE OF ORISSA

The population of Orissa, which was 316.60 lakh in 1991, has increased to 368.05 lakh in 2001 exhibiting a decennial growth rate of 16.25 percent as against 20.06 percent in the previous decade and 23.86 percent at the all-India level. The density of population has increased from 203 per sq.km in 1991 to 236 per sq.km in 2001, which is lower than the all-India average of 313 per sq.km. Increase in the literacy rate from 49.10 percent in 1991 to 63.08 percent in 2001 was significant. The male and female literacy rates have gone up to 75.35 percent and 50.51 percent respectively in 2001.

1.2.1 State Income

The Gross State Domestic Product (GSDP) at constant (1999-2000) price of Orissa has increased from Rs.42527.07 crore in 1999-2000 to Rs.63774.71 crore as per the advance estimates in 2006-07 registering an annual compound growth rate of 5.96 percent over the period. (Economic Review, 2007-08).

1.2.2 Education

Education is an important input for human resource development. Improvement in awareness and skill is possible only through education in various areas. The literacy rate in the State has increased from 15.8% in 1951 to 63.8% in 2001 (Economic Review, 2007-08). During the same period, the female literacy rate has also increased from 4.5% in 1951 to 50.5% in 2001. (Economic Review, 2007-08). During 2006-07, there were 46,722 primary schools with 44.85 lakh enrolment and 1.14 lakh teachers. During the same period the number of upper primary schools was 16,403 with 18.17 lakh enrolment and 0.36 lakh teachers. There were 7408 high
schools with 13.52 lakh enrolment and 0.62 lakh teachers. One primary school (female) for every 3.7 sq.km. area with a teacher-pupil ratio of 1:41 in 2000-01 then has increased to one school for 3.3 sq.km area with the teacher-pupil ratio coming down to 1:36 during 2006-07. (Economic Review, 2007-08). The State is committed to Universalisation of Elementary Education (UEE) with a view to attaining Millennium Development Goal.

1.2.3 Health Services

Adequate healthcare and easy access to health services are indispensable for overall human development. State Government have been making sincere efforts to provide adequate healthcare services to the people within reasonable distance from human habitations. A number of schemes are being implemented to improve healthcare facilities in tribal and backward regions.

There are 181 Allopathic Hospitals, 231 Community Health Centres, 114 Primary Health Centres, 1164 PHC (New), 90 Mobile Health Units and 6688 Sub-centres in operation. Besides, 5 Ayurvedic and 4 Homoeopathic Hospitals, 619 Ayurvedic, 560 Homoeopathic and 9 Unani dispensaries are also functioning. In addition to these a number of medical institutions are there in the private sector.

The birth rate, death rate and infant mortality rate which were 22.7, 9.6 and 77 respectively during 2004 have further declined to 21.9, 9.3 and 73 respectively by the end of 2006. (Economic Review, 2007-08).

1.3 SURVEY OF PAST RESEARCH

Cedric, Sharma, Goyal (1999) have observed in their book titled “A practical guide to hospital planning and management” that the management of the hospital today is a cumbrous process. They have attributed three specific reasons to this process. Medicines are becoming technology intensive, management and planning have also become very scientific. Last but not the least, patients are beginning to have rising expectation for healthcare delivery and the management has to respond to their needs.

Goyal (2005) in this book named “Hospital administration and human resource management – 4th edition” has observed that there is advancement in
human resource management like technology and medical science. Not long ago, employees were treated like commodities in an organization, but today, they are seen as the most valuable assets of an organization and treated like partners in the management. This book envisages the latest strategies in human resource management in hospitals to face the challenges of changes brought about as per the report of the steering committee on health for the 10th Five-Year Plan. Further, also it is advocated by this author in this book that high quality patient care is the result of not only medical expertise, modern equipments and drugs, but also of the efforts of a well motivated, disciplined and well-rewarded workforce in a medical institution.

Satapathy (2004) titled “Biomedical waste management in India” has observed that the enactment of biomedical waste (management & handling) Rules, 1998 has made it statutory for Indian hospitals. He has emphasized that waste treatment and disposal would lead to waste minimization. In his view, waste minimization is an eye-opener and should capture the attention of the healthcare workers and the administration for ensuring a fruitful implementation.

Shortell and Kaluzny (2000) in the book titled “Healthcare management: Organisation, design and behaviour” have observed that today’s healthcare executives may be faced with the most challenging managerial assignments. In a high pressure environment where consumer demands for comprehensive services, insists on efficiency, cost control, a renewed emphasis on quality healthcare, etc., managers must pursue strategic goals and objectives to ensure survival as well as progress. Increased demand for information regarding the quality and outcomes of care and improved information system technology will undoubtedly lead to enhanced accountability standards. These and other measures in turn will create a further mandate for the reinvigorated approaches to healthcare management and leadership.

Wickramasinghe, Gupta and Sharma (2004) have observed in their book titled “Creating knowledge based healthcare organizations” that healthcare in the 21st century is facing three very large forces of change; namely, an informed and empowered consumer, the need for e-health adaptability and a shift from focusing primarily on cure to prevention of diseases. On the contrary, the cost of delivering quality healthcare is increasing exponentially. Hence, reducing this expenditure as
well as offering quality healthcare treatment is becoming a priority globally. New business and technological advances have the potential not only to reduce these costs but also, and equally importantly, to make it possible to achieve high quality, high value and high accessibility to healthcare delivery systems. Thus, the adoption of such advances, specifically knowledge management strategies, processes, techniques and tools into the healthcare industry may not be a panacea for addressing all of today's current healthcare challenges but is certainly an important component for a solution. The author also focuses his attention on applying automatic data collection tools for real time patient management and dealing with problems as to scheduling and over crowding and improving the quality of care through the use of automated patient management system. The author highlights on the need of healthcare sector to learn from other industry sectors and embrace techniques to help decrease the growing percentage of medical errors.

Hosking and Hoggard (1999) have observed in their book titled “Healing the hospital environment” that we and other patients entrust our health to the skills and commitment of doctors, nurses and therapists and we take it for granted that our safety is their paramount concern. Any built environment or the way it is presented gives a message but too often the NHS presents a negative message that no one cares about either the building, its surroundings or those who use them. He views that NHS is so lacking in money that it cannot provide aesthetic delight and normal standards or comfort and thus undermines the confidence of all who use it. The author has suggested that real improvement can be made by making a small financial investment in design expertise and then allowing those experts to use existing resources in the best possible way.

Finkler (2000) has observed in his book “Financial management for public, health and non-profit organizations” that managers and policy makers of public health service organizations must have a working knowledge of financial management and they must be able to understand and make use of financial information. Their needs are oriented towards getting and using financial information to make decisions and manage effectively.

Allcorn, Baum, Diamond and Stein (1996) have observed in the book titled “The human cost of a management failure – organizational downsizing at general
hospital" that the healthcare industry is faced with the changing technological, social, ethical, legislative; judicial and market place agendas that demand the utmost from the management and employees of hospitals. Downsizing restructuring and reengineering have become popular responses to the need for change. As per his view, organizations cannot downsize their way to excellence. In theory, re-engineering and downsizing eliminate unnecessary work; in practice these responses eliminate people implicitly defining them as unwarranted costs and underperforming expenditures.

Geisler, Krabbendam and Schuring (2003) have authored the book titled "Technology, healthcare and management in the hospital of the future". They explore the major transformations that technological innovation have brought to the worldwide healthcare system. They view that healthcare delivery organizations are notoriously ineffective in adopting and applying new technologies. But they ultimately tend to utilize innovation in both the clinical and managerial aspects of their existence.

A research undertaken by Economic Research Foundation (2006), New Delhi on “Government Health Expenditure in India – A Benchmark study” has evinced that government spending on health has been undermined during the period of economic liberalization since the early 1990s creates a concern and need to be investigated. In the developed countries, the ratio of public health spending to private health spending is much higher. In contrast, in the middle-developed and low-developed countries, either private expenditure dominates or there is very little difference between the shares of private and public expenditure although in general both tend to be low. India has the lowest ratio of public to private health expenditure among all the developing countries. Further, all the private expenditures in India are constituted by out-of-pocket expenses. This is inherently regressive and puts a disproportionate burden on healthcare of the poor households.

Bhat (2000) in his study on “Management issues in funds disbursement to implement health sector programmes : case of family welfare programme” has viewed that funds and other resource flow mechanisms do have significant implications for programme performance. These affect the ability of health sector programme managers to use funds and determine how resource will be used to meet
the people’s health needs. The central sponsored programmes have been an important policy initiative of Government of India to support the health sector programmes. The paper reviews that centralized focus would provide proper direction and thrust to specific health problems of national importance and management and implementation issues could be handled more effectively. This paper also reveals that the present financial management system of the government is not adequate to handle the complexities of programme implementation.

DFID (2003) in Orissa in case study titled “Working together towards a healthier future” in their report on Human Development, 2003 has indicated that the root causes of poor health in Orissa are chronic poverty and low levels of awareness that lead to insufficient demand for healthcare and hence contribute to inadequate spread of good quality health services. In this report, DFID pledged its support to Government of Orissa from infrastructure to system improvement. DFID supported Orissa Health Sector Reforms Project while started with the objective of supporting Government of Orissa to look at the changes in this sector by pinpointing the needs of the most vulnerable, rational use of funds, decentralized system of planning and management including increased community participation.

Kumar Girish (2004) in his study titled “Public hospital reforms in Madhya Pradesh (India): Perceptions and trends” has focused on achievement of the scheme of Rogi Kalyan Samitee (RKS). This paper has viewed that the RKS heralded a major initiative to reform the near-defunct government hospitals in Madhya Pradesh. This paper has also come up with the view that RKS is an organized effort to bring about a change in the behavioural pattern, work ethics, inject the sense of duty and mould the traditional mind-set of the health functionaries in order to make them the de facto harbingers of change.

Ravindran (2005) in his paper on “Health sector reform and public-private partnerships for health in Asia: Implications for sexual and reproductive health services” has focused on public and private sectors working with a complementary and collaborative approach. Public-Private Partnership (PPP) and the increasing role of private sector in healthcare are the themes which currently occupy a central position in health sector reforms agendas throughout the world.
Colton (2007) in his article titled “Strategies for implementing performance measurement in behavioural healthcare organisations” has observed that performance measurement provides a basis for demonstrating accountability and a foundation for performance improvement. Nonetheless, practitioners tend to be cautious of attempts to assess the efficiency and effectiveness of behavioural services, particularly given the qualitative nature of some treatment interventions (such as process oriented therapies).

Balgir (2007) in his article titled “Medical genetics in public health administration in India: A handicap of Bureaucracy, bias and corruption” has observed that public health and health administration are the fields meant for communication of relevant health information account for healthcare priorities, policy and delivery; manage crises; and address major health concerns. He has pointed out that there is lack of training in under-graduate as well as post-graduate level in medical education for public health administration in India. Bureaucracy handles the public health administration in India for which neither they have expertise in medical health nor in public health administration, resulting in health bias and corruption. He has suggested that satisfaction of the public / or community should be the criteria of judging performance of employees and their retention. Updating knowledge and acquiring need-based skills every year through refresher course should be introduced as public health administration is an ever challenging responsibility. He has viewed that the government should ensure security, stability and independent functioning of the same. Political pressure in any way should not interfere with the functioning of the organization.

Mohanty (2008) in his article titled “Citizens turn around public hospitals” has viewed that Rogi Kalyan Samitee (RKS) are revolutionizing public healthcare in Madhya Pradesh. He has emphasized on public participation in public healthcare. He has evidenced the case of Maharaja YashoBant Rao Hospital, Indore where the user charges for all hospitals facilities collected by RKS could be distributed to different departments for upgrading equipments and employing contractual labour for maintenance.

Pandya (2000) in his article “Strikes by Physician in public hospitals in India” raises the question if strikes by resident doctors training to become
consultants in Indian public sector teaching hospitals be ethical. In his view, these hospitals were established for the medical care of the very poor in a country where health insurance and a National Health Service are non-existent. In such a situation, the paralysis of tertiary healthcare centres by striking doctors runs contrary to the raison d’être of the profession. Although there is some discussion in the western countries on strikes by doctors, authority in India are silent on the subject.

Mohapatra, Srilatha and Sridhar (2007) have observed in the article “A patient satisfaction survey in public hospitals” that corruption appear to be very highly prevalent and was the top cause of dissatisfaction among patients on public hospitals. Other important areas of hospital services contributing to patient dissatisfaction were poor utilities like water supply, fans, lights, etc., poor maintenance of toilets, lack cleanliness and poor interpersonal communication skill. High level of dissatisfaction was also pointed out regarding patients’ assessment of technical quality of doctors’ work and time spent by them. They have suggested that patient’s satisfaction survey forms an important tool for managerial intervention in public hospitals.

Bhattacharya, Mohan, Koushal and Rao (2006) in their article titled “Study of patients’ satisfaction in a tertiary referral hospital” have given some key messages pertinent to the management issues in the public hospitals. Their messages reveal that patients expect doctors to fully explain the disease, cost and treatment plan before hospitalization. They have clearly suggested that attitude and behaviour of nurse and paramedical staff towards attendants need to improve. They point out that for a healthcare organization to maintain and improve its standard, constant monitor of perceptions and expectations of the patients and their attendants is essential.

ICFAI University, Tripura (2008) in the course description on “Master of Hospital Administration” highlight that consequent upon the growth of Indian economy and rise in the household incomes, there has been increasing demand for quality healthcare. There is a gap between demand for and supply of hospital services in India particularly in rural areas. This gap is created mostly due to the indifference in the public sector. This article points out that public health expenditure in India is low in comparison to other developed countries. However, the author expresses his satisfaction in the fact that there are some recent
government initiatives which focus on improving healthcare access, boosting private sector participation and upgrading technology. This article suggests that managers in hospital and healthcare industry would have to understand the service delivery process and should have a through knowledge of all costs and work towards improving patients satisfaction under the opportunities and challenges.

De (2007) in his book titled “Public system management” has viewed that the government as regulator and promoter of healthcare services has a major role to play in promoting and regulating hospitals in private sector. The state governments encourage growth of general hospitals and specialty treatment hospitals in their states provided an agreed proportion of the proposed capacity in the hospital is reserved for treatment of poor people at an agreed concessional rate. Some of the state governments prefer installation of an outpatient department and a family welfare organization in a hospital for services to the general masses at subsidized price. Further, emphasis is given on the availability of adequate number of personnel with task oriented training for improving the coverage and quality of health service.

Centre for Development Studies and Activities, Pune (2000) in its article titled “Monitoring of social inputs in Ganjam and Nuapada districts of Orissa – Sectoral overview, Part-I” has observed that government expenditure on health and number and volume of all types of health providing units is inadequate. They view that the effectiveness of the healthcare system is dependent on availability of recurrent spending and adequate maintenance of existing health services and infrastructure.

Kilpatrick and Johnson (1998) in their book titled “Handbook of Health Administration and Policy” have observed that if only patients and enrolled population were involved, it seems clear that mainstream management methodology would be sufficient. Caring for patients, populations and communities involve quite different mind sets and data sets and methodologies that are not readily compatible through purely business management techniques. Continued escalation of all costs of healthcare in this country has renewed the need to manage the public health. This management can be accomplished through the development of interrelated communities they serve.
OBJECTIVES OF THE STUDY

The specific objectives of the present study are as follows:

1) To study the level of satisfaction of patients, both indoor and outdoor towards various services provided by the public hospitals.

2) To analyse the adequacy of the hospital staff (Doctors, Nurses, Mid-wives, etc.) in the public hospitals.

3) To examine the work efficiency of the hospital staff in public hospitals.

4) To study the cleanliness standard and other facilities provided by the public hospitals.

5) To identify the areas of services in urgent need of attention in the public hospitals.

6) To give suggestions for improvement of services in any allied activities of public hospitals and to recommend some important suggestions to the government regarding management of public hospitals in Orissa.

HYPOTHESES

Keeping in view the above objectives, the present research endeavours to test the following hypotheses:

Hypothesis 1: Patients with high education, income and occupation react sharply to the deficiencies in services than the patients with low income, education and occupation background.

Hypothesis 2: Urban patients are more satisfied than their rural counterparts with the services/facilities provided by the public hospitals.

Hypothesis 3: The public hospitals in general are not tidy and clean.

Hypothesis 4: Urban patients are more aware and privileged in getting services from public hospitals than their rural counterparts.

Hypothesis 5: Doctors and paramedical staff of public hospitals are sincere in attending the patients and in serving them better.
Hypothesis 6: Government has provided adequate staff and other facilities for doctors and staff in public hospitals.

Hypothesis 7: All required medicines and medical investigation facilities for treatment of patients are available in public hospitals.

1.6 RELEVANCE OF THE STUDY

Health is a fundamental human right and a world-wide social goal, the achievement of which permits people to lead a socially and economically prosperous life. There is close interrelationship and interdependence between health and socio-economic development. Again, health leads to a progressive improvement in the quality and conditions of life. But the health status of thousands of people in the state “Orissa” is unacceptable particularly in rural areas. It is so because of inadequate and inequitable distribution of health resources within the state for which political, economic, social and cultural reasons can be attributed to. Thus a gap has been observed in the commitments of the Government in the field of healthcare and fulfilment of health needs of the people of the State. In many national and international conferences on healthcare, the slogan “Health for all by 2000” has been unanimously resolved. But this does not mean that every single individual is to be provided with all possible high tech medical coverage. In this context, only “Primary Healthcare” may be considered to apprise the continuing performance and efficacy of launching such a programme in our state, i.e., Orissa.

It is admitted that primary healthcare is a service and is considered as the state’s responsibility to provide it out of public revenue raised. In order to properly discharge this responsibility, the state has to formulate and enunciate a health policy in close co-ordination with that at the national level irrespective of political affinity and prejudice. In order to ensure uniform health services in primary areas for all citizens of Orissa, the State Government has certain policies. As a step towards implementation of such policies, the Government of Orissa has set up primary health centres, sub-divisional hospitals, district hospitals, teaching hospitals etc. which are called public hospitals. Such public hospitals have specific aims and objectives and have identified areas of services to reach the suffering teeming millions in rural, urban and semi-urban areas. These are the units used for disbursement of health.
services for fulfilling the constitutional commitments of the Government of our State. Considering the situation of public hospitals and healthcare system of the Government of Orissa, many research study groups and news agencies come-up with many unpalatable views on the functioning of such institutions which very often create uproar in parliament and turmoil in the public.

So, a need was felt to pursue a study on the management of public hospitals run by the Government of Orissa and different municipalities under the caption “A Study on Management of Public Hospitals in Orissa”.

1.7 RESEARCH DESIGN AND METHODOLOGY

1.7.1 Sources of data

The present study is mainly based on primary data collected through structured questionnaire from doctors and hospital staff, urban and rural patients of various groups of income, occupation and education (both male and female). Secondary data also are collected from the annual reports of Health and Family Welfare Department, Government of Orissa, WHO Bulletins, Medical journals, Orissa Economic Survey, Development Study Report, UNICEF Materials, various other books, articles etc.

The population for the sample study consists of doctors and patients in urban and rural areas of the state of Orissa. The sample has been obtained by following stratified random sampling technique from urban and rural respondents of different sex, education, income and occupation groups. The study was conducted personally from 12th April, 2007 to 3rd November, 2007.

1.7.2 Sample size and sampling

A sample of 420 patients was selected out of which 270 are from urban and 150 are from rural areas. The respondents from urban areas were selected from six major towns of Orissa, i.e., Bhubaneswar, Cuttack, Sambalpur, Berhampur, Puri and Rourkela. The respondents from rural areas were selected from the districts of Dhenkanal, Nayagarh, Jagatsinghpur, Balangir, Rayagada, Jharsuguda, Koraput, and Kalahandi. Thus while selecting the respondents, enough care was taken to select them from various parts of Orissa to make the sample more representative. Out of
total respondents in urban areas, male are 150 and female are 120. Similarly in rural areas, male are 100 and female are 50. A sample of 120 doctors, 100 nurses and 50 other staff were selected for the study and also interviewed for the purpose.

1.7.3 Techniques used for data analysis

The responses collected from patients, doctors, staff nurses and other administrative staff have been edited and tabulated. Percentages have been widely used for comparing and analyzing the data. Chi square technique is used to analyse the difference between the expected frequencies and observed frequencies and to study fluctuations in sampling at 5 percent level of significance.

Areas for this study included various services rendered in OPD and IPD of public hospitals. These services are examined from the point of view of outdoor patients, indoor patients and doctors and hospital staff separately. The patients were requested to indicate their level of satisfaction and point out areas in need of urgent attention. Both the patients and doctors and hospital staff were requested to give their suggestions for improving the efficiency of public hospitals in giving various services.

1.8 RATIONALE OF THE STUDY

The present study is concerned with various services of public hospitals provided to the indoor and outdoor patients. The services include quick disposal of patients in the outdoor, thorough investigation in pathological, radiological and blood bank areas, availability of medicines, quality of food, cleanliness of hospital linen, emergency services, attendance of doctors and staffs in casualty, wards, ICU, etc. The attitude and behaviour of doctors and other staff towards the patients are analysed in this study. Even the areas of weakness where services can be improved are also suggested. The study aims at arriving at the concrete conclusions and to suggest some important and effective steps to improve the areas of deficiencies in services and to provide a healthy ambience for the patients and their attendants.

The present study analyses the causes for deficiencies in services by the doctors and hospital staff and suggests to overcome such deficiencies. This study is expected to provide a reasonable quantum of fuel for thinking and rethinking as to
how best the public hospitals can be managed. Even some of the findings are expected to go a long way to guide the planners, policy makers, administrators and public as well. Furthermore, these findings are likely to hold good in other parts of the country as health service is a basic need of every citizen and a primary responsibility of every government.

1.9 LIMITATIONS OF THE STUDY

The present work cannot be claimed to be free from limitations. It suffers from the following limitations.

➢ The areas of coverage of urban and rural are limited to particular cities and localities.

➢ Time and resource constraints have limited the scope of the study.

➢ Since the staff are all govt. employees, it is difficult to get accurate information from them.

Despite these limitations, the study is expected to throw adequate light on various deficiencies in the management of public hospitals. Some of the findings and suggestions are expected to be useful for planners, policy makers and the government.

1.10 ORGANISATION OF THE STUDY

The present study is organized into six chapters.

The first chapter introduces the topic of the research, outlines the objectives, hypothesis, rationale, research design, methodology and lastly, the limitations of the study.

The second chapter presents the historical perspective of public hospitals in India and Orissa as well as a brief profile of public hospitals in Orissa. This chapter also discusses briefly about health planning, management and programmes in India vis-à-vis Orissa.

The third chapter examines the various types of services provided by public hospitals in Orissa.
The fourth chapter analyses the style of functioning of public hospitals as regards their management and administration, manpower planning, financing, etc.

The fifth chapter analyses and interpretes the primary data collected from urban and rural respondents or patients across sex, occupation, education and income and also from doctors, nurses and ancillary staff.

The sixth and last chapter summarises the findings and observations; and suggestions have been recommended to government and policy makers for overcoming the deficiencies and lacunae in the management of the health sector in Orissa.

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