6.1 Introduction
The present chapter being the concluding chapter of this research endeavor brings together the various standards of conceptual and theoretical promises as also of the imperial investigations in an attempt to present a balance picture of the management practices adopted by the hospitals in Nashik.
The chapter is divided into three parts:
First: It records the first-hand observation of the research is also the conclusions derived at the end of data analysis exercise.
Next: It offers meaningful concrete and viable suggestions to improve the working of the hospitals.
Lastly: It outlines certain topics for further research / investigation.

6.2 Observations
1. Nashik city: the study area has century-old (172 years) tradition of medical services. In later years successive plague and cholera and recently swine flu (H1N1) epidemics hit the area. The Government hospital builds its impeccable reputation for quality medical care during the calamitous period. But now lacks of positive attitude of all segments of the concern system darken the image of this oldest government hospital Nashik. Patients literally run away from the hospitals to private hospitals after admission due to several reasons including hygiene is found to be the most important factor.

Over the years it also acted as nucleus for the emergence of specialty hospitals and clinics in Nashik city. Today about 2000 large and small hospitals with a collective bed capacities of 20000 plus and dedicated to specialties like gynecology, orthopedics cardiothoracic, pediatrics, ophthalmic, ENT, psychology, leprosy, tuberculosis, cancer etc. The city’s landscape and their number are still rising. For the present research work, only 75 hospitals with 35 plus bed capacities were taken up for investigation from Hospital management perspectives.

2. Except for three large hospitals owned and operated by charitable trust and the municipality, the rest majority have been constructed on the plot of land as have come to be located in the tenements as became available from time to time. Some hospitals are housed in rented premises; still some others are located in congested areas. Many hospitals neither have protective compound walls and boundary fencing nor adequate vehicle parking space, nor their own access roads. The
growth and development of so many hospitals, though a contribution to the large society, it has taken place in a mundane rather than in planned and phased manner.

3. Except for large hospitals, the rest here not worried them over constructing a hospital-specific building. As a result patients and visitors difficulties begin right at the hospitals’ entrance. Absence of ramps for wheel chairs and trolleys, steep flight of stairs, narrow doors and corridors, sharp turns, dark corners, inadequate lighting and ventilation, unkempt toilets, floor plan displays, name boards and sign boards are conspicuous by their absence, compounding the confusion further. Both inside and outside paint work on the buildings is neglected years after years, giving the structure a depressing parlor.

4. Majority hospitals also lack the basic amenities and facilities like waiting spaces(together with reading matter), drinking water, toilet facilities, canteen / refreshment stall, wash basin, and sinks, wheelchairs, patient trolleys and stretchers, lifts etc. to alleviate the patients’ / visitors’ anxiety and agony. In other words many hospitals were not pre planned but put together in a haphazard manner. The only inference that we can draw is that the doctors have made themselves busy catering to the patients’ problems neglecting the infrastructural part of the hospitals.

5. Large hospitals follow streamlined OPD (out-patient department) care admission procedure, beginning with punctual arrival by the attending physician, medical staff and service personnel. As a result despite patient’s rush, these hospitals perform with clockwork precision.

   In small and medium hospitals, particularly those run by doctor-entrepreneurs, punctuality is observed more in its flouting, doctor’s do not come to hospital at appointed hours, throwing the consulting and surgery schedule off for the day. Rarely do they seen realise that a few minutes delay in the morning coalesces into may hours backlog by the evening, putting the doctor himself, the hospitals staff and the patients / visitors under considerable strain. As a result many time, patients are compelled to extend, their hospital stay by on additional day. Quite often the OPD patients either go back untreated or go looking for another less crowded clinic. In spite of taking patient’s cognizance, the scheduling function of the doctor’s visit is below satisfaction.

6. Most often hospital staff (receptionist) found as causal about their duties as they generally busy playing remote control of TV set or personnel mobile phones in
reception/waiting area. They neither respond properly with the patients/relatives who are waiting for medical advice outside of OPD/consulting room.

7. At last, by taking the cognizance of frequent cases appeared about attack on doctors-nurses by relatives of the patient after sudden death of their wards, most of the hospitals now under electronic surveillance. It gave additional sense of security against theft and clouds of terrorism. Still security system is not up to the mark and found so may loop holes in these regards.

6.3 Findings / Conclusions

The conclusion being presented in the following paragraphs are based on the empirical data gathered from three sets of respondents namely (doctor), hospital staff and patients that has been presented and interpreted accordingly in the preceding chapter. Likewise here also, the conclusions are being presented under these tiles - hospitals, hospital staff and patients.

6.3.1 Hospital functioning

1. The ownership pattern shows that an overwhelming majority of hospital (89%) in privately-owned and operated. Institutional owner (trust and local authorities) own and operated rest (large hospitals with 100 plus bed capacity) 48% doctor-entrepreneurs financed their hospitals through private sources, 37% through commercial bank’s assistance six hospitals by international aid agencies, two by governments and three has been set up by local authorities.

2. Category-wise, about 2/3rd is surgical, 1/4th consultative/clinic and about 10% are nursing homes. Size wise number of hospitals up to 79 beds dominated (44%) followed by hospitals with 50 beds (32%) i.e. more than 3/4th hospitals are small and medium sized. Still a significant number of hospitals (10%) had above 100 beds. Bed occupancy varied between 30-100%; 65% being the average occupancy rate. But ten hospitals revealed 100% occupancy throughout the year. In 53% hospitals admitted up 10 new cases every day, 30% between 11-25 cases and 7% hospitals 20 plus cases.

3. Majority 77% hospitals have side laboratories for conducting routine blood, urine and other tests. All 100% hospitals have an O.T. with less or more modern facilities and 68% hospitals have a radiology department. 27% hospitals had a pathological laboratory and 91% hospitals had well equipped ICU. Some 47% hospitals also offer other facilities like ANC.PNC, ECG, EEG, USG and family
planning, physiotherapy etc. In 26% hospitals offer MTP procedure and 7% hospitals had dialysis equipment, 5% had organ transplant facilities and 4% had mortuaries. Some of these hospitals also had a blood banks attached to it. The remaining hospitals either relied on local blood banks run by a charitable institutions or asked the patients to make their own arrangements. Two hospitals offer CT scan and MRI like advanced diagnostic facilities. The hospitals needing these were sent to privately own diagnostic centers. The medical and clinical equipment support at Nashik city thus appears to be well developed.

4. Radiology is an important diagnostic tool in the array of modern healthcare. Total 77% had X-ray department and between them they owned 66 X-ray machines. Except for three large hospitals however no other hospitals employed qualified radiologists. It was also observed that some hospitals, though having own X-ray machines did not employ qualified X-ray technicians but entrusted the work to self-trained freelancer who usually worked for two -three hospitals on the contract basis or available on call from concerned hospitals.

5. Out of total sampled hospitals claimed to stock all essential drugs in their medical store, 30% hospitals also had a separate pharmacy and 16 %hospitals had in house pharmacy. As per Pharmacy Act 1948 and regulation of State Pharmacy Council; every hospital must bears license with registered pharmacist for sale of drugs. But it was a very common practice of appointing skilled non-pharmacy personnel for the handling of pharmacy services. The same pharmacist found running of two or more medical shops in different hospitals. No professionalism about community/hospital pharmacy services found, rather all these services were dominated by doctors. Perhaps FDA authorities were unable to control all these activities due to lack of manpower.

Most of the hospitals had retail medical stores within their premises to reduce their drug-carrying costs and as a convenience for the patients. In patients eyes however, the arrangement renders of a under hand linkage between the prescribing doctor and the medical shop owner.

6. Majority 90% hospitals had OPD block /room, included in OPD were the facilities like dressing room in 77% hospitals, injection room in 70 % hospitals, and sample collection room in 73% hospitals. Only in 32% hospitals however, the OPD block -room was under supervision of a medically qualified person. About 13%
hospitals used their OPD for Health education and family welfare counseling purpose.

7. Out of the sampled hospitals 4 % hospitals attended up to 41-50 cases per day. And around 1/3 \(^{rd}\) (42%) hospitals 60-80 OPD cases per day. About 1/4\(^{th}\) hospitals 25% recorded average 81-90 cases per day, while 30% hospitals handled more than 100 OPD cases per day.

8. Generally, 1/4\(^{th}\), 25% hospitals recorded 750-2000 OPD patients per month. However, 24% recorded average monthly attendance 2001 to 2250 and 2251 to 2500 each. Around 30 % hospitals recovered near about 3000 OPD patients per month collectively for the hospitals tend to support to Nashik City’s reputation of being medical town.

9. It was revealed that only in about 27% hospitals (which are incidentally are large/medium sized hospitals), supervision over the day to day functioning was entrusted to a separately designated hospital administrator/medical superintendent in the remaining hospitals the doctor–entrepreneurs perform to shoulder these responsibilities also in addition to his/her main work. These doctors trying to in act dual role mostly unsuccessfully. If may also be that majority of these doctors are not aware of the modern hospital management techniques to get best out of their men, materials and resources. Interestingly in 39 % of the hospital heads stated that they had delegated decision making authority to their subordinates. These arrangements however remains unsubstantiated in view of the one-man show picture already emerged

10. Large hospitals prepared a roaster of doctors to be available round the clock. In small and medium hospitals, however the situations was quite different, while in some entreprunial instances , doctor had their residences on the top of the hospitals; in other cases they tended to locate the residence nearby the hospitals. This however did not significantly improve the availability of doctors for night time between its reporting and the doctors’ arrival on the scene.

11. None of the hospital was found to conduct equipment audit or medical audit. In large hospitals, there was an awareness of this aspect and in small and medium hospitals the promoter-doctors were too occupied to pay any serious attention to it.
12. Computers have made significant role on the hospital scene in
the Nashik city and it is happened that there would eventually bring some
systematization to the adhocism on which majority of hospitals see to survive.

13. With this we come to end of the broader conclusion about functioning of the
hospitals studied. The picture that has been emerged is far from satisfactory. As
can be seen only a few large and old hospitals are functioning being run
systematically. The newer small hospitals that have come up on the
entrepreneurial enthusiasm of their promoter doctors are far below the norms of
an effectively functioning health care institution. Sadly in many instances the
monetary drive of promoter overshadows the service element associated with
noble medical profession.

6.3.2 Hospitals Human Resource

1. It is surprising to find that in spite of well-developed growth of medical profession
in Nasik city, qualified nurses are conspicuous by their absence, in that only 4 %
hospitals employed nursing graduates and 43% hospitals employed nurses with
qualification like ANM, General nursing etc. The remaining bulk lined just HSC, SSC
qualified young women and imparted them perfunctory training in nursing/ patient
care. In 40% hospitals did not even bother for these basic minimum educational
qualifications. Two reasons are possible for this lopsided picture; either the
remuneration of qualified nurses is beyond the promoter-doctors paying intent as that
they wish to under pay the importance of a qualified and trained nurse in the
functioning of their hospitals. Consequently in the study area the designation as a
medical helper, Ayah, Dai stand modified as a nurse. About the nurses working in the
midnight shift it was found that majority (17%) hospitals required only two nurses of
course, the size and type of hospital were the important factors influencing the
availability of their nurses in the night shift.

2. In 75% hospitals nurse record maintained in the ward itself to facilitate easy access
and were served central record only after patient’s discharge. In about 1/5th hospitals
nurses practiced in the health education programmes in the OPD. Five hospitals
provoked residential accommodation to their nurses with in the hospital premises
itself. This arrangement while on the one hand offered greater convenience to nurses
in turns of reduced to and fro travel fatigue on the other hand, it also automatically put
them on 24 hours call. Lastly on overwhelming majority 45 of hospitals reported of
73% turnover of nurses. About 10 hospitals with 13% turnover of nurses, this is
keeping with the poor or absence of qualifications among these ladies and because of
the pressure of their circumstances; they are forced to hold onto their employment
while some them enjoy sense of security in their jobs in government or trust owned
hospitals.

3. It is already reported that about 77 % hospitals have side laboratories and more than
2/3rd hospitals have X-ray machines. These facilities required trained manpower to
operate. However, only about it 25% hospitals employed technically qualified people,
the rest relied on so called self-trained technicians also only about the 41% were
technically qualified the rested acted up to HSC/SSC qualifications .Thirty six
hospitals had a laundry attached to it and the numbers of laundry staff varied between
3 and 10 depending upon the hospital size.

4. Interestingly, in spite their sizable no (about 4000 ) in Nashik city, the hospital staff
is not unionized, the staff union in the city’s largest hospital even not functioning and
the promoter of other hospitals are certainly adverse to the idea. Consequently
workers continue to wallow in their misery nursing from par wages, job in security,
harsh working conditions, lack of welfare measures etc. in spite of these being
adequate legislation on lend to protect the workers interest. History repeatedly shows
that labours laws tend to work better were unions are present to force their
enforcement.

5. More than half (46%) hospitals relied solely on the work experience while recruiting
new man power and 40% hospitals get equal weightage to educational qualification
and work experience. After appointing new staff however only hospitals issued
appointment order and 20 hospitals provided written job descriptions. Only 40%
hospital claimed of imparting induction training absolutely lack of medical approach
and the trainer are just given verbal instructions about how to do their assigned jobs.
No hospital including large one had appointed a training officer nor had prepared
training manuals. The on the job training procedure popularly adopted by these
hospitals was a misnomer as it failed to provide guidance to and supervision over the
trainees.

At the end of this exercise of parenting conclusion about the personnel
practices adopted by the hospitals in the Nashik city. It is sad to comment that in
general these practices are far from being enriched towards rendering quality services
to the patients.
6.3.3 Hospital management practices

We now turn to other area of Hospital management:

1. Different hospitals used different approaches to handle their financial matters. In about 20% hospitals the promoter doctor himself had willing fully undertaken this responsibility, about 40% hospitals entrusted this task to on outside chartered accountant. Only 11 hospitals had their in house accounting department. The problem is that in majority of cases, the C.A. used for taxation matters and in no cases can be expected to look after day to day accounting tasks. Where the promoter doctor looking after the financial affairs, the problem of role duality rears its head, in that an individual can either be a competent doctor or competent accountant but not both together rolled in to one. Since the finance is the critical area of hospital a management, the picture that emerges into their behalf is not at all that of a disciplined organization.

2. Purchase and store of equipment drugs and hospital supplies wield a significant influence in the overall functioning of the hospitals. In Nashik city, only an insignificant mainly (28%) of hospitals had set up a separate purchase and store dept. In 30% hospitals the purchases were centralized and handled through timely initiation of purchase orders, follow ups for delivery and systematic procedure for receipt and inspection of materials. Surprisingly about 40% hospitals did not use any inventory control techniques at all, while the rest relied on techniques such as minimum stock, physical verification and ABC analysis. About stock replenishment also nearly ½ (46%) hospitals relied on need based replenishments i.e. hand to mouth buying, the rest following system such as drug basket exchange and par level/tapping up. It was also revealed that only a few hospitals stocked emergency drugs in their medical store, rest relied on nearby medical shop. Obviously the hospitals were not paying due attention to inventory management and it would not be surprising that if no deeper investigation it is found that inventory is one of the area from where maximum losses resulting from pilferage etc. are reported in the hospitals.

3. Out of 75 hospitals all 100% hospitals owned ambulances, 73 % hospitals had just one ambulance while 03% owning of fleet of four. The hospital (13%) that do not own ambulances either ask the patient to make the necessary arrangement in emergencies, call the charitable institutions that operate subsidized ambulance service. About the hospitals that have ambulances, however there is absolutely no
control on supervision over the use of these vehicles. None of the hospitals even maintain such rough records as driver’s logbook, vehicle servicing and repair records, daily mileage and fuel consumption report etc.

4. Medical equipment maintenance section existed in five large but no hospital had a building of maintenance section, the work being usually given out to contractors. All these (100%) hospitals had installed generating set ups in case of power failure. It is difficult to deliver any concrete conclusion about equipment maintenance set up of the hospitals because though many hospitals have installed sophisticated equipments, some attention is being paid to its operating and servicing aspects.

5. Nearly 86% hospitals used the traditional information system of files and registers, a small 14% having fully computerized system in the hospitals. Among the sources used by hospitals for acquiring current topical information, mainly relied on medical magazines and journals, a sizable numbers of hospital heads also attended medical seminars and conference and referred up to date medical books. A majority 86% had acquainted themselves with the use of video films. About all hospitals had their own medical libraries, 33% may stocking up to 200 hundred titles and two large libraries stocking over 1000 titles.

6.3.4 Hospital Staff

The next few paragraphs present the conclusions derived from the analysis of the data collected from the hospital staff.

1. On the whole majority of the hospitals staff of Nashik city belongs to the middle age groups (29-39 years). Absence of young age service employees is perhaps because people tend to enter late and retired early from the hospital related occupations. Majority of the staff preferred to locate their place residence within walking distance from the hospital where they worked. Education level wise nearly 50% staff was qualified only up to the minimum requirement for securing employment. Though some staff was highly qualified but none was found to possess hospital administration specific qualification.

2. On the average nursing staff comprises only 41% of the total hospitals man power, rest holding administrative, no nursing technical jobs. This indicates that besides nursing staff hospitals requires substantial administrative and technical people for their functioning. The average hospital employees were found to be 5 to 12 years experienced although majority 49% staff worked for eight hours every day, the
rest was putting 10 and over 12 hours. Among the leaves facilities, the staff tended to restart to sick leave by majority. This is probably because being informal sectors organisation, may hospital does not have definite leave rules and the staff is forced to give the pretext of sickness for seeking leave. Post-retirement benefits was the grossly neglected aspect of hospital employment, only 71% hospitals offered contributory EPF, 21% gratuity, and 8% family pension benefits to their employees.

3. Majority of staff grievances resulted from heavy workload and inadequate salary, wages. The grievances were mostly taken directly to the hospital head instead of being solved through proper channels, probably because of undefined organisation structure. About 2/3rd of the staff was dis- satisfied over their salary/wages and heavy work load. This coupled with no advancement opportunities for lower grade staff like Ayah, Dai, ward boy, watchman, OT assistant, technician etc. has made the hospitals work environment a seething cauldron of discontent.

4. About 44 % of the hospital staff was aware of their inadequacies in performing their assigned duties and the need for proper training to improve their performance. By majority they preferred to be trained within their employing hospitals itself. Self-development was the primary drive behind the staff’s desire for getting trained, followed by the desire for increased wages and contributing to the fulfillment of the organisational goals. Interestingly a miniscule (6%) staff expressed that they do not face difficulties in their work, the rest admitted that there indeed are difficulties and attributed these to such reasons as lack of training, wrong placement, lack of orientation, communication gap and ignorance of the nature. These are very serious flaws in any human integrative business enterprises, particularly the hospitals, which ultimately affect enterprise’s efficiency and profitability. Hence the hospital staff does not seen to be taking pride in their work.

**6.3.5 Hospital patient**

The next few paragraphs recorded the conclusions derived from the data gathered from hospital patient. The hospitals being servicing-delivery, institution, the opinions of the service beneficiaries-the patients- can equal weightage in assessing the overall performance of the hospitals.

1. About the perceived professionalism of the doctors patients generally were satisfied. Majority of the patients however, felt that fees charged by doctors are on
the higher side. An assessment of the doctor-patient interaction recorded on elements of mutual considerations, but here too the patient felt that the doctor had made them undergo various tests and procedures without giving adequate justification. Patients were utterly dissatisfied with their interaction with hospitals staff and felt that the staff exhibited exploitative behavior.

2. Diagnostic communication between doctor and patient has come out in poor light from the patient viewpoint. This is probably because of the technology arrived set-up of the modern day hospitals inadequacy to understand the full implications of doctors advice and perceptions.

3. About the doctor patient auxiliary communication though the patients were generally satisfied with the doctors, their medicinal prescriptions and the instructions about their consumptions, the doctors insisted on buying the medicines from the particular medical shop irritated them greatly.

4. Lastly, the patients were generally satisfied with the treatment and the care to they received during their hospital stay.

6.4 Testing of Hypothesis

The hypothesis were tested of present study revealed that:

1. In the hospital, Owner/Administrator and other supporting staff have informal Relationship, therefore there is harmony.

The average hospital employees were found to be 5 to 12 years experienced (Table 5.2.6) although majority 49% staff worked for eight hours every day, the rest was putting 10 and over 12 hours (Table 5.2.7). Among the leaves facilities, the staff tended to restart sick leaves by majority. This is probably because being informal sectors organization, many hospitals does not have definite leave rules and the staff is forced to give the pretext of sickness for seeking leave. Post-retirement benefits was the grossly neglected aspect of hospital employment, only 71% hospitals offered contributory PPF, 21% gratuity, and 8% family pension benefits to their employees (Table 5.2.9).

Majority of staff grievances resulted from heavy workload and inadequate salary, wages. The grievances were mostly taken directly to the hospital head instead of being solved through proper channels, probably because of undefined organization structure. About 2/3rd of the staff was dis-satisfied over their salary/wages and heavy work load (Table 5.2.12). This coupled with no advancement opportunities for lower
grade staff like Ayah, Dai, ward boy, watchman, OT assistant, technician etc. has made the hospitals work environment a seething cauldron of discontent.

This hypothesis was found negative as far as harmonious relation in between the hospital, owner/administrator and supporting staff. Still they continuing their services perhaps, there were no new employment avenues for these non-technical, unskilled manpower or they lost their confidence to secure new jobs in this competitive market.

2. The hospital authorities are applying all modern techniques of hospital management for better patient care.

In this hypothesis it was revealed that patients were found satisfactory about the services provided by their attending doctors. The doctor’s interaction with patient is reflected in (Table 5.3.5) which has returned on above-average mean score (X) 13.20. The doctor's seem to be giving an ear to what the patients have to say and reciprocate it by carefully examining the patient and informing them about their health.

Table 5.1.8 shown the various facilities available with the sampled hospitals. The table reveals that 77% hospitals were equipped with laboratories, all 100% have Operation Theater, 68 % hospitals offer radiology services, 27% hospitals operate pathology laboratories; 90% hospitals are equipped with ICUs and 47% hospitals provide other facilities such as ANC, PNC, Solography, EEG, ECG, physiotherapy etc. Overall it is sent that the ancillary services infrastructure is purposefully developed and maintained by these hospitals to offer batter patient acre.

3. I am very satisfied with the medical care I received from the doctor.

This hypothesis thrown the light on factual part of the hospitals and their services, according opinion of the respondents it was found negative. It (Table 5.3.6) revealed the fact that the staff’s interaction with patient reflecting mean score (X) of 5.35 and from the sampled population (of 54.49% and 56.77% of the respondents), showed their dissatisfaction due to lack of co-operation from the hospital staff. It was stated by respondents that right from the day of admission in the hospital records from the patient in case their expectations were not fulfilled, the patient were neglected without much personnel care and attention.

The fees charged by the doctor’s do not seen to be reasonable as the mean score for 2.80 for this variable is barely (hardly 40%) patient confirming the reasonableness of fees (Table 5.3.4).
After studying the various aspects of hospital services as a concluding experience the general attitude of the patients towards these services was taken cognizance of the mean score (X) indicated for the general attitude is 3.70(5.3.9). The patients’ overall experience in the hospital has led to the forming of this attitude, which is above-average. This fact correlates with the saying that “Health is wealth”. The respondents are also satisfied with the services offered by doctor hence in spite of several deficiencies in the functioning of the hospitals, people are willing to spend money and bear unpleasant experiences, with the objectives of fast recovery from their illness/sickness.

6.5 Suggestions
As stated in the beginning of the Chapter-I, hospitals have grown into among the more complex and dynamic institutions of our society. Concurrent with this description accelerating changes are taking place in the environment in which hospitals exist and function. If this history of the changing perspectives is any indication of the future. It is only certain that the hospitals even in the foreseeable future will have to function in much competitive rigidly regulated environment and more importantly with unprecedented efficiency and effectively.

Their challenges will mainly arise from declining sources, patient’s pressure for specialized services, manpower fluctuations, technological changes and multi-institutional arrangements. The Suggestions presented in the following paragraphs are based on this historical condemnatory and future perspective of the hospitals in Nashik city.

1. Amenities wise and facilities wise, the hospitals in Nashik city have come out in not poor light. It is high time that they took initiative in removing the various physical deficiencies on the premises. The thought that the patient is not an intrudes on their premises but is the purpose of their existence should dominate their thinking. Hence everything possible within the hospital’s means should be done to reduce the patient’s anxiety and offer him success while maintaining his dignity as human being.

To begin with outside walls of the hospital building may be painted with bright and cheerful colours. Inside the place, due attention be paid to details like lighting, ventilation, cleanliness, hygiene, toilets and sanitation, signboards and direction arrows, organisation charts, hospital bed charges etc. Because of the absence of an exclusive authority regulating the functioning of the hospitals through which
observances of different laws and rules could be enforced, it is for the medical profession itself to uphold its norms abide by regulations and respect its ethics. The reception area should be manned by competent persons throughout the hospitals working hours. The medical records of resident transferred and recently discharged patient should be handy in the reception area so that anxious enquiries about those can be fielded promptly.

As the reputation of the hospital grows people instinctively look up to it help in emergencies. It therefore, becomes a social responsibility of reputed hospitals to have well equipped casualty cum OPD under the overall charge if senior medical officer capable of responding swiftly in emergencies.

2. A major impediment to the efficient use of available diagnostic and curative equipment lies in the absence of technically qualified and trained personnel to operate these that in turn is traceable to the absence of requisites training facilities in the area. In this behalf it could be suggested that the local medical association through liaison efforts may take lead in establishing appropriate medical equipment training centers in collaboration with the local engineering colleges and other technical training institutions.

3. We have identifies three causes for the absence of trained nursing staff in Nashik city hospitals namely, poor paying intent of the doctor entrepreneurs, tendency to underestimate nurse and hospital pharmacists role and non-availability of adequate training infrastructure. Discounting to the first two idiosyncratic causes, we concentrate on the third one. Here also the local Municipal authority in collaboration jointly with, Local universities, local educational institutions and large hospitals may establish a school of nursing to train suitably prequalified and attitudinally inclined local talents. Such an initiatively the one hand will generate educational and employment opportunities in the area on the other hand, it will meet the local hospitals need for trained nursing personnel.

Both these training facilities (medical equipment, operation and nursing) will be an endeavor in value addition of this rural area is human resources and the fulfillment of social obligations by the local medico in return for their peaceful and prosperous practices.

4. It has come out that both equipment and building maintenance though considerably important remain mostly neglected by the hospitals because of the pressure of day to day functioning. It is felt that the local medical association should extended enormous
help to its members if it takes lead in setting up a pool of technical expenditure in this behalf. To begin with it may impel local and nearby civil engineers, medical and maintenance engineering contractors negotiate their fees for different jobs on assignments and contract basis and circulate the panel list among the member hospitals.

The hospital would then contact the empanelled contractor directly when needed and reported to medical association after the job is satisfactory completed. The association may charge nominal charges both to the contractors and the hospital authority for meeting its administrative expenses.

We now turn to the functional area of the hospital management. The numerous inadequacies of the hospitals large, medium and small - in Nashik city hence already been presented in the preceding pages. These inadequacies are the result of general interlinked as well as independent causes of managerial rather miss-managerial nature. Taken together however; these have imparted a general malaise to almost all the hospitals in the city.

The measure for the reframing/remolding the hospitals will therefore have to be suggested both in individual functional areas as also collectively for the entire profession with this purpose the following suggestions are being offered:

5. **Managements** the core responsibility of the management comprises planning, organising, staffing, directing, coordinating and controlling. In this behalf the doctor-entrepreneur have a long way to go in shaking off their orthodox attitude bordering on lethargy of running their hospitals as ad-hoc thinking. They then have to learn scientific hospital management practices and techniques avenues. In this connection again local medical association would off immense help initially it may be collaborative with local and nearby management schools and pharmacy colleges in arranging short term courses in hospitals management for its interested members.

Latter on it may set up a hospital management consultancy cell under its own auspicious by drawing on the expertise of local/nearby management consultant, faculties of management schools, techno-commercial experts and specialists in different management areas. It may also be requested to local management schools, pharmacy colleges to open short time courses on hospital management and ask the association members to sponsor aspiring candidates for it.

It has already come out that computer have played their vital role on the hospital scene in Nashik city. These machines can be highly helpful to the hospital
management administration if used properly. Recently certain application specific software useful for individual doctors and hospitals also is come on the market. It is felt that the hospital would benefit substantially if they explore y computers fully in their service.

Lastly, it is researcher’s humble opinion that university courses lending to the MBBS, BDS, Pharmacy, BSc (Nursing), BAMS, BHMS should include a compulsory paper in hospital management, so as to better orient the medical/healthcare graduates to knowledgeably manage their occupation.

6. Finance - Turning to specific functional area of management, we first take up finance. It is already reported that in the hospitals being studied, financial management is mostly acknowledged through its neglect. Financial planning and budgeting are paid no attention, eventually the repercussion of this neglect are experienced in the area of working capital management and costing/pricing of medical services. Too low pricing reflects in the compromise on service quality, while too high pricing results in creating feelings of exploitation and alienation among the patients. The data collected from the patients confirms that these feelings are entrenched deeper in the patients. Majority of hospitals also ignore systematic account keeping, much less adopt control procedures. In fact base minimum accounting records, attitude of majority doctor-entrepreneur while saving a few tax rupees for time being, would eventually prove to be the base of their numerous financial problems. If the doctors themselves are unaware of proper accounting procedure on it they do not require a full time accountant on the premises. They hold entrust the work to outside competent individual /firms. The Feedback from properly kept accountant would help them in planning their financial strategies for future growth and development.

7. Medical services - Then next financials area of the hospital management is efficient unsatisfying delivery of medical services in the community. The intra moral factor that influence the quality of medical services are hospital site and building, diagnostic and curative equipment, casualty and OPD services, nursing care, pharmacy and drug store, auxiliary services like laboratory, ambulance, blood bank, surgical facilities, sterilization, laundry, infection control, life support equipment like compressed Oxygen, ICU and at the periphery, canteen and recreation.

The empirical data has indicated various short comings of Nashik City hospitals in this behalf. Overall there is considerable room for improvement and
improvisation and it is for the promoter-doctor themselves to take initiative in this direction. They may also seek expert help from established and reputed hospital management consultancy firms and further may learn a lot by keeping in touch with current literature or hospital management and with model renowned hospitals.

8. Personnel - Personnel rather human resources rank as per with two earlier discussed areas. Finance and medical services-in the hospital management. The picture that has been emerged in Nashik city hospitals is far from being satisfacory. The hospital staff was observed to be totally unsatisfied with their salary/wages, working conditions, welfare facilities etc. Consequently, their work alienation and frustration appeared to be irreversible. At the same time, they were not unionized for pressing their demands and improving their lot through collective efforts. For the fear of the victimization and even losing their employments. One can very well imagine the adverse effect of their low employment morale and seething discontent on the quality of medical services offered by the hospitals. In any case promoter-doctors would do well to realise the crucial importance of the people working in their hospitals have a long way to go in establishing cordial relations with their staff, create a warm and trusting workplace atmosphere, develop a team spirit and a sense of belonging to the organisation, which all together lead to increase in the staff’s productivity and the hospitals profitability.

In today’s competitive world on enlightened entrepreneur fiercely guards over his resources-material and men- the twins that would ensure the success of his business in the market place. In fact human resources development (HRD) has emerged as an important area of modern management services. The hospitals in Nashik city sooner or later will have to wake up to this realization.

9. Marketing - This brings us to last functional area of the management-that is marketing. Riding on the momentum of the Nashik city’s century old reputation as a historical, industrial, agricultural and educational medical town. The hospitals today enjoying a seller’s market. The boom time however is not going to last much longer now, as already a great corporate hospital has papered on the horizon. The new Medicare institutions would offer a comprehensive package of preventive, diagnostic, curative, and rehabilitative treatment under one roof operating control being in the hands of large business hours even multinational and trans-multinational companies and with the chain of hospitals set up at multiple locations. The corporate hospitals information base, material resources and specialist taken would be summaries that
entrepreneurial hospitals would be poorly marked to complete against them. Working through complex arrangement with other corporate employers they will design by meeting the health care needs of corporate sectors, employees, expand into alliances with insurance companies affecting mediclaim, Medicaid health care covers and externally linking up with the country’s social security network, may even take over the grass root level PHC and public hospitals. This will certainly push the entrepreneur hospitals in the periphery of the integrated public health care system. Thus today’s sellers, market in medical service would oversight turn into a buyers’ market covering the empirical hospital in to facilities and manpower standard establishment shunned by the community.

Even in such a drastic scenario, competitive edge cans still remain with smaller hospitals only if they offer personalized quality medical care bas on scientific hospital management techniques.

6.6 Suggestions for future research
The following topic is being tentatively suggested for future research:
1. Assessment of the training records of hospital staff and of quality awareness in them.
2. Medical equipment and medical service audit in specialty hospitals.
3. Measuring a quality of medical service audit in patients view point.
4. It is also fact that the following promising hypothesis were merged for future testing:
   a. Satisfaction towards salary package has a bearing on the staff’s category.
   b. Hospital ownership influences the type of medical and surgical facilities.
   c. Initial sources of financing influences the type of medical and surgical facilities.
   d. Bed capacity of the hospital is influences by the type of ownership.
   e. Bed occupancy rate have given influence in the ownership of the hospital.
   f. Need for training the hospital staff has its being on the staff category.
   g. Hospital staff training has an influence on the difficulties in discharging duties.
   h. Delegation of authority with the staff has a being on the ownership of a hospital.