Chapter-VIII
CHAPTER - VIII

PROBLEMS OF HOSPITAL MANAGEMENT

1. PROBLEMS RELATED WITH GOVERNMENT POLICIES

- Poor Accessibility for Disadvantaged Groups
  Policy-makers in the government and especially in the Ministry of Health and Family Welfare need to redefine health policy to ensure priority of health care to disadvantaged sections of the society. The overall gains in health are being overshadowed due to increasing disparities between rich and poor. Such inequalities are both unnecessary and unjust. Equity is a value that governments subscribe to, but do not always make explicit in their policies. The importance of emphasizing this value is that it is often overlooked in today's attempts to tackle the financial problems of health care. Health systems are in turmoil, partly because of severe economic difficulties in some.

- Absence of Planned Regionalisation to ensure Graded Patient Care
  At present, all hospitals whether at the state, district or local levels are working in isolation and their services are not provided in a coordinated manner. Most of the patients visit all these hospitals and are examined afresh by all of them resulting in wastage of efforts and resources. The medical staff prescribe medicines to
patients without having a proper knowledge of his previous treatment.

• **Medical Audit not a Regular Feature in most of the Hospitals**

Following drawbacks are observed in some of the hospitals:

i) Poor recording of a case history.

ii) Sketchy documentation.

iii) Operation notes not properly recorded.

iv) Lack of inter-departmental coordination.

v) Incomplete case-notes.

vi) No proper follow-up by the senior faculty members.

• **Developing Missionary spirit among the Health Personnel**

The problems of public health are challenging as gauged from the statistics already enumerated. It is very difficult to solve these problems with bureaucratic and inhuman attitude. It requires hard work, sympathy, and tolerance on the part of the health personnel engaged in this arduous and challenging task. Most respondents felt that the personnel working are fulfilling only their legal duties and that too reluctantly.

• **Lack of Community Health and Health Administrative Research**

Huge sums of money are poured out annually on clinical hospital–based research in most States of India. One would not underestimate the importance of this type of research because it
adds to knowledge. However, one has to think in terms of defining the priorities of research. A country, where the bulk of people are living in the rural areas, should normally involve the greater number of doctors doing research in community health. India is one country which cannot boast of even a single good epidemiological study of such communicable diseases as tuberculosis, from which a sizable number of people suffer every year. In fact, the area of community health research does not encourage clinicians to work in the rural areas. The problems of community health, no doubt, are vast and intriguing. Yet, the country cannot afford to ignore them.

- **Private practice by Government functionaries/doctors**

  It has been observed that government hospital’s doctors are engaged in private practice in spite of the fact that most of the state are paying non practicing allowance (NPA) to them. Thus attitude results into neglect of their duties of hospitals and poor patients who cannot afford deprived of medical care.

- **Absence of comprehensive health legislation**

  In the states, legal provision with regard to health lie scattered over a number of acts. At present, there is only one state i.e. Tamil Nadu, which has a comprehensive public health act satisfying reasonably the requirements of the modern health administration. The present corpus of health legislation is inadequate resulting in piecemeal decisions.
• **Imbalance between the Rural and Urban Areas**

There has been an imbalance in the availability of medical facilities and health manpower in rural area. Rural people have become conscious of their rights. They demand and deserve good quality health services. Even the government itself is critical of this situation. It was stated officially that it is an unfortunate fact that four decades of health services development resulted in concentration of 70% of medical manpower and facilities in urban areas where just 30% of the total population resides.

• **Unsuitable system of medical Education**

It has been expressed that teaching in medical colleges still requires a radical change for its orientation towards the need for community care. Medical education over the years, has been urban biased. It is hoped that it would be possible to produce medical graduates who are aware of the health problems of the community, who have a sense of compassion and motivation to serve the public and who have ability to effectively meet the urgent needs of the health care problems of the rural masses and the urban-poor.

• **Research Bears no Relevance to Practical Problems**

There has been a lack of cooperation and coordination among the institutions engaged in teaching and research. This results in disjointed, isolated and rank duplication of scientific research in several national laboratories resulting in waste of scarce resources.
Over the years, for a variety of reasons the medical research programmes in the country could not follow the path of problem-oriented medical research in priority areas such as nutritional disorders, control of communicable diseases, operational research for providing health care to all, research in medical education, health manpower planning, utilisation of health personnel, research in indigenous system of medicine, etc.

- **Fragmentation of Sectoral Responsibilities at National Level**

Health affects and is affected by other socio-economic factors. There is little coordination between the Ministry of Health and Family Welfare and other ministries to ensure sustained development. Besides, there is no attempt to educate, empower people to ensure equity. To quote World Health Organization:

“There are numerous obstacles to the creation of health-supporting environments, not least of which is the fragmentation of sectoral responsibilities at national level. In many countries, health remains the concern of a single ministry rather than a goal to which each sector or ministry, traditional boundaries between government and non-governmental organizations, and between the public and the private sectors, hinder the development of strategies and policies informed by an awareness of health and health needs.”

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This fragmentation can reduce the impact of health-promoting activities, particularly those undertaken at the local level. It is of only very limited benefit.

Participation and empowerment are also the key to reducing the gaps between the “haves” and the “have-nots”. This inequality not only results in disparities in health status but also prevents groups such as women, elderly people, children and indigenous people from playing a full role in creating health-supporting environments.

- **Lack of equity in Health care**

  We have to empower the poor people so that they can take their due from health care system. As long as the services do not reach the needy people, there cannot be any perceptible change in the health status of the people. Services are not to be merely accessible but must reach those most in need.

  We must plan and implement our health system to ensure quality health care to the poorest section of the society, which currently does not exist.

2. **MANAGERIAL AND ADMINISTRATIVE PROBLEMS**

- **Inadequate Facilities**

  Health facilities in India face many operational difficulties. These include inadequate funding for drugs, supplies and other consumable, shortages of diagnostic facilities and laboratory equipment, and a general deterioration of physical infrastructure.
These major constrains lead to a low quality of care and inefficient functioning of the system at first referral units in the district health system.

- **Absence of Well-Designed Management Information System**

State government has performed the ritual of setting up statistical bureaus dealing with health. Huge health statistics have also been collected but these have been put to a bare minimum use in terms of utilising this information for developing a realistic health care delivery system. Thus, the ever-widening gap between accumulation of health statistics and their utilisation for improving health services has of late acquired new problem.

- **Poor Quality of health care**

Quality is becoming an essential part of the health system in both developed and developing countries. Quality Assurance in Health Care is not a programme. Quality Assurance is a process, which is a continuous one. Quality of Medical Care is an index of Civilization. Health Care Quality is being demanded and expected and providers are judged by it. Quality is tangible and measurable. It is cost effective. Quality is as simple as doing one’s job better continuously. There is a great pressure from patients and general public for quality health care which is based on certain standards, accreditation, certification and bench marking.
• **Stereotyped Health Management System**

The challenge of Health for all calls for a permanent and systematic managerial process, ranging from planning and policy-making, in collaboration with other sectors, to implementation, monitoring and evaluation, for the development of an effective health system. The managerial process entails the formulation of health policy with defined priorities, and the preparation of programmes and budgets to put the policy into effect. It also calls for the assessment of manpower requirements and the formulation of plans to train the requisite manpower, together with the integration of Well-formulated programmes into the general health system. A dynamic civil society and a professionally trained and dedicated civil service (Insulated from political interference) are the twin pillars of a constructive relationship between State and Society.

• **Unsatisfactory System of Drugs and Medical Supplies**

The efficiency of hospital services depends not only on the competence of medical personnel but also on the availability of drugs in right quantity and quality. There are a number of problems in regard to the drugs management in hospitals.

Some government hospital authorities were in league with drug suppliers. By manipulating records and accounts, hospital stores returned part of their stocks to suppliers for a financial consideration, or sold them to chemists at rock bottom prices. Often drugs obtained under the Central Government Health
Scheme or the Employees States Insurance Schemes were found to be falsely indented and sold to chemists.

Certain medicines consumed by patients in the hospitals were sub-standard. There have been periodical reports of shortage of certain medicines and it appears that no effective machinery exists to take notice of such shortage in time for remedial action in a coordinated manner.

Thus some important problems may be listed as under

i) Pilferage of drugs.

ii) Purchase of drugs at higher prices from the open market because of lack of advance planning.

iii) Use of adulterated drugs.

iv) Shortage of essential drugs.

v) Corruption among the authorities in a hospital.

vi) Qualified persons not responsible for drug management.

vii) Absence of regular inspections to check the drug stores.

viii) Use of expired drugs.

- **Absence of Proper Space Planning**

A large number of hospitals in the state have come to be established and housed in buildings which were not originally designed for the present needs and technology. The planning of hospital facilities in such a changing situation within the
constraints of the existing space availability is one of the biggest problems that any hospital faces.

There is also lack of coordination between the hospital authorities and transport authorities resulting in the poor transport facilities available to the patients.

• **Poor management of Dietary service**

   The dietary unit stands as the second major department of a hospital from the point of view of expenditure. Most of the patients always complain of poor and costly diets served in the hospitals. There is a problem of excess diets issued as compared to the number of patients resulting in huge expenditure. Besides, many of the patients do not consume all that is served to them. Patients generally prefer food from their houses as they do not like hospital food.

• **Poor Quality of Service**

   Quality of care is very important for patient’s health. Quality assurance means making sure that the services provided by the hospital are the best possible. Quality assurance is vital for the hospitals clinical support services (x-ray, laboratory, pharmacy, central sterile supplies) which have an obligation to maintain high standards. There is no quality care in CHC hospital. Hospital effectiveness which can be measured in term of patient’s satisfaction does not depend on the improvement of hospital services aspect alone but on the medical care aspect also.
• **Inadequate Infrastructural Facilities**

Linen, urinals, latrines, bathrooms were extremely hopeless which is a very sad reflection on the functioning of CHC and other hospitals. Cleanliness is the first and most important aspect of a CHC and hospitals as it affects the organisational climate. This is more a question of attitude and not much of resources. Patients and relatives feel suffocated with stinking smell all around. Hospital buildings are old at some places and electricity and lighting facilities are inadequate.

• **Poor quality of medical Record keeping**

Medical record is a scientific, clinical, administrative and legal document relating to patient’s care in which is recorded sufficient data to justify diagnosis, treatment and results.

Good record-keeping is essential. If medical records are illegible, incomplete, ambiguous and incorrectly filled, they affect medical care adversely. The quality of medical records is an important managerial and medical consideration.

Analysis of record revealed the following:

i) Medical Record Keeping is not taken seriously resulting in poor quality of health services.

ii) Decision-making by a Doctor who has not examined himself in first instance becomes difficult and irrational.

iii) It causes complications in Medico-legal cases.
iv) It avoids the evaluation of medical competence of the MO/SMO concerned.

v) It is a major hurdle in making referral system a success for which these CHC and hospitals have been created.

- **Nurses involved only in clinical Activity**

  The real foundation of health can be laid if nursing is properly developed for primary health care hospital. Nurses do not participate in other than clinical activities this blocks their involvement in other activities nurses are over burdened in their clinical activities and therefore, are unable to involve themselves in other activities.

- **Technical, Administrative and managerial problem indentified under five year plans**

  i) Inadequate investigation and data collection as a result of which the hospital appraisal, even when it is sought to be done in a systematic way, has to be carried out on the basis of wholly inadequate information, thus leading to wrong investment decisions.

  ii) Inadequate detailed planning of hospital in terms of their time schedules, input resource requirements and skills needed for project implementation.

  iii) Lack of delegation of authority to subordinate organization levels.
iv) Delays in issuing sanctions, approvals, fund authorizations and releases.

v) Organizational weaknesses in planning and implementation at various levels.

vi) Lack of specific assignment of responsibility and accountability for results.

3. PROBLEMS OF HUMAN RESOURCE MANAGEMENT

- **Non – availability of Dedicated Doctors/ Worker to serve in the villages**

  The doctors prefer to serve in the cities rather than in the villages. When they are forced to work in the villages, their mind is always in the cities. This results in lower efficiency of the Primary Health Centres. Other paramedical staff even fourth class employees do not prefer to work in rural areas. This is a big problem that how to look after the health and related problems of 70% of Indian population as it is known that 70% population of the country lives in villages. The government efforts by making rural service and postings for doctors compulsory in rural areas have failed.

- **Problem of injecting Creativity and Dynamism among Health Personnel**

  The quality of personnel appointed to take care of health care activities, levels of efficiency, motivation and enthusiasm have not been maintained at a high level and there is lack of devotion to duty on the part of the medical and paramedical personnel.
Complaints by the citizens regarding inefficiency and lack of devotion to duty on the part of medical and paramedical personnel have become quite articulate, and many people are even losing confidence in the existing primary health care system thereby widening the credibility gap.

- **Unsatisfactory management of Employees’ State Insurance Hospital**

Hospital under Employees’ State insurance Scheme have not been functioning well. The shortage of doctors and medicines is the common ill of these institutions. There have been complaints from the beneficiaries about the malfunctioning of these hospitals. For examples indoor patients are not served food in the utensils owned by the hospital it is observed that the food is distributed on piece of papers. Complaints of corruption among the staff and doctors are quite common.

- **Absence of Effective Personnel and Materials Planning**

In most of the hospitals, there is no personnel planning, resulting in the under utilisation of resources. Expenditure on personnel is mounting high and care must be taken to ensure optimum utilisation of resources. After the personnel, materials constitute about 50 percent of the total expenditure of an organisation. The asset utilisation in hospitals are not taken care of.
Shortage of medical and para medical staff

Against the sanctioned strength of 12,336 of medical staff, 9,953 (81 per cent) were in position as on 31 March 2008. The shortfall was significant (49 per cent) in respect of female specialists and 11 per cent in male specialists. The shortfall in general male specialists was 24 per cent. Similarly, against the sanctioned strength of 53,498 of para-medical staff, 41,159 (77 per cent) were in position. The shortage of staff had a direct bearing in delivery of specialised medical services under the RHS which was the main objective of establishing CHCs. In 101 CHCs of the 16 test checked districts, the shortage of specialists ranged from 32 to 76 per cent and para medical staff ranged from 30 to 69 per cent. Similarly, in 719 PHCs shortage of MOs was 34 per cent and para medical staff ranged from 7 to 48 per cent. It was also observed that in 15 CHCs and 19 PHCs of the seven test checked districts, 39 doctors posted in CHCs/PHCs remained absent unauthorisedly for the last 1 to 10 years but no action was initiated against them as of August 2007. The Government in reply stated that efforts were being made for filling up the vacancies. No reply was given by the Government regarding unauthorized absence of these doctors.

- Quality of Behaviour

A courteous and soft spoken staff of the hospital not only gives a good name to the hospital but also creates a place in the heart of thousands patients. A simple good behaviour of the staff may cure
a patient psychologically up to 50% Personnel's including doctors of the hospital should always remember that a patient is a poor troubled person and has come in the hospital with the hope of a helping hand on the part of the employees of the hospitals. Corruption charge is a very common charge against the employee of the hospital. A director of hospital should not forget to punish such offending staff.

- **Low job satisfaction**

The quality of the health institution run by Government would be dependent to a great extant upon the quality of the employees engaged in their operation. Personnel run the health system.

Among the three component required for developmental tasks – men, money and material – it is more the men (or the human element) then any other factor which determines the quantity and quality of the performance and output. After all even the contribution of money and material to performance depends substantially upon their manipulation by the men in an organization.

- **Lack of managerial Training on the part of the Hospital Administrators**

Hospital Administration is a science as well as an art. The hospital administration has become complex and requires administrative capability to solve its managerial problems to provide optimum care to the patients. The persons charged with the efficient running of the hospitals are not trained in the managerial
techniques and tools which may be applied by them for getting the best out of the resources available. This creates a problem of non applicability of management techniques in hospital administration.

4. PROBLEMS OF FINANCIAL MANAGEMENT

• **Inadequate Financial Resources**

It is one thing to define health needs of a given population and another thing to adequately plan health services in accordance with their needs. No aspect of planning health services appears to be more important than the consideration of finance. The paucity of financial resources because of poor allocation has often proved to be a major obstacle in the execution of health programmes. With the meagre resources, one cannot expect much. At present, the health department of Uttar Pradesh is being allocated only 3-4 per cent of the total resources for the promotion of health. The task of providing health care to improve the quality of life of the people is challenging.

"Financial resources mobilized through alternative mechanisms, such as cost recovery and user fees are minimal at this stage, being less than 10% of the total recurrent health expenditure. It has therefore become increasingly difficult to meet the unprecedented rising cost of health care."¹

• **Wasteful Expenditure**

There are a number of reasons which result into wasteful expenditure

¹ SEA/RC20 pp. 39-40
(i) The health system is not well organised. Because of inadequate referral system, there is lot of duplication, overlapping and improper use of services resulting into huge costs. Tertiary health care, which is highly costly, is being used for primary health care. This also results in poor manpower utilisation.

(ii) There is maldistribution of health resources. Most of the health budgets (about 80 per cent) are being spent only on a few people (20 percent). This deprives the people living in rural areas and urban slums.

Essentially, the continuance of poor health standards is indicative of a less than optimal use of resources available. Some aspects of this are the emphasis on curative, as opposed to the preventive techniques embodied in the existing hospital systems, the inadequate development problems of indigenous medicine system on which there is a continued reliance and the limited coverage of available medical facilities, particularly in rural areas.

(iii) The serious challenge in this field is the rising cost of health services beyond the reach of most of the people inhabiting the developing societies. It is very difficult to afford the costly urban based hospitals using highly sophisticated technology. A huge amount is being spent on costly buildings and equipment, which the developing countries cannot afford. The only services which can meet the health needs of the people are low cost services, which should be efficient and effective.
(iv) The problem in this connection is the lack of coordination among different agencies financing health care services. This may result in wasteful duplication of efforts. Besides, many health services may not get the desired financial allocation because of this wastage. The situation can be improved through proper coordination among such agencies.

(v) A serious problem in health care administration the absence of cost consciousness among the staff of public health administrations. All over the world, health service staff – even of the highest professional cadre – are taught little about the economics of health services and know little about the costs of the equipment and supplies they use. Doctors tend to employ what is new without regard to cost. It is a fashion to prescribe costly drugs. They are also subjected to considerable sales pressure from manufacturing firms.

(vi) The problem is the use of hospital services non-judiciously. In the more developed countries, the majority of secondary care is generally given in hospitals, and increasingly the hospitals in which it is provided tend to be large, i.e. 500 beds or more. The larger hospital offers the opportunity for a high degree of specialization and for achieving the fullest use of expensive specialized equipment. The larger the hospital and the more specialized its work, the larger catchment area it needs to serve. The higher average transport costs for staff and patients may be justified by the quality of service that a large hospital should be able to provide.
• **Budgetary Problems**

The traditional budget reveals that Government purchases but not why, it indicates what government buy, but not what the government does. The traditional budgeting fails to provide adequate link between the financial outlays and physical targets. According to Mr. S.S. Visvanathan, “An expert in the field of performance budgeting, there are the following four shortcomings in the conventional budget which arise mainly out of systems of classification”\(^2\).

i) The classification does not serve as an adequate base for informed decision – making at each level of management. It does not help management to control and appraise performance of the various programmes, projects, activities and schemes.

ii) It is difficult to see from the existing budget and account heads for what board purposes and objectives resources are being allocated.

iii) The classification does not permit a proper analysis of the impact of government transactions on the total national economy.

iv) It is not helpful as a basis for judging the progress towards the achievement of goals and objectives as envisaged in the development plans.

v) Zero – Base Budgeting may face the following problems in the Indian context:

a) It would increase a lot of paper work and would be a costly and time – consuming exercise.

b) There is dearth of well-trained personnel in this area.

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c) It would require a well organized Management Information System.

d) Re-deploying of resources from low priority to high priority is a very sensitive issue, as it involves the manpower.

e) Plan and Non-Plan expenditure distinction carries no significance in this exercise.

f) Center-state relations in finance create problems of utilization.

- Ineffective Utilisation of Resources

The most serious problem in India is not as much of Resource mobilisation as that of resource utilisation. The resources are not producing the desired impact.

K.N. Rao, in a paper on “Health in Developing Countries” pointed out: It may be stated, however, that even funds allocated by WHO and UNICEF are not fully utilized in some developing countries including India due to administrative and procedural difficulties.

In this regard following problems are noticeable:

i) Lack of effective policy-making, planning and decision-making to exploit the human and financial resources for the welfare of the people.

ii) Lack of coordination among the allied agencies and within the various units of a department resulting in duplication and wastage of financial resources.

iii) Lack of reliable, timely and suitable information systems for the formulation implementation and evaluation of financial policy.

iv) Widely scattered funding mechanism with little control over costs.
v) Use of outdated methods and procedures in the operation of the financial administration.
vi) Lack of interest to improve financial administrative structures and procedures.
vii) Lack of equity of distribution and adequacy of coverage in relationship to need.

5. ENVIRONMENTAL PROBLEMS

Environment includes all these conditions, circumstances objects and influences surrounding and effecting the development of organisation. Environment is taken as given. It is not fully controlled, but management can definitely influence it or affect it to some extent in the long run – through its far-sighted managerial skill, experience, discretion and vigilance. The hospital organisation has to work in a given environment. In fact, any organisation is a sub-system of a larger social system. Hence, it affects and also being affected by the external environment. External environment of hospital organisation includes along with other things relatives of patients, respectable citizens of the area, general public of the society, Government and its policy, politicians etc.

During survey on sample centres, the doctors accepted that external environment does affect the working of hospital organisation. One of them said “The relatives of patients behave very rudely and sometimes they directly reach to the higher authority for their small complaints and create problems. Hospital staff becomes demoralised due to this and it has adverse impact on the working of
the hospital organisation. Public hospitals have to follow the rules and regulations fixed by the Government. Dealing with Government for doing anything is time-consuming process and is very tiresome some job.

From medical point of view apart from human factor, natural factors also cause worry to the hospital management. The hospital campus environment may be polluted due to medical waste disposal, solid waste, radioactive and toxic wastes.

The hospital management has to face the problem of their proper disposal there is some mechanism and arrangement of proper disposal of these wastes but in small hospital it is a big problem to be cracked.

6. TECHNOLOGICAL PROBLEMS

With the advancement in the technology latest scientific techniques and machines are introduced to check and treat the human health. It is a very complexed problem of government hospitals that these machines and equipment can only be operated by those technicians who have completed specialised training to do so. If such technician goes on the leave, the whole of the work related with him come to stand-still as no other employee can substitute him. Such monopoly gives a rise to corruption among the employees. It may be noted that more often than not expensive and sophisticated medical equipment for conduction essential diagnostic tests are under utilized in
Government Hospitals and dispensaries on account of, inter alia lack of qualified para medical staff.

7. PROBLEMS HIGH LIGHTED BY RESPONDENTS

- **Outdoor patients**

During the survey of three cluster namely ‘A’ ‘B’ and ‘C’ respondents highlighted the following problems related to outdoor patients department (OPD)

**Problem of OPD**

i) Lack of proper seating arrangements.

ii) Delays resulting into time wastage – it takes 2-3 hours for a patient to get his turn.

iii) Lack of punctuality – Doctors on duty are not in time resulting into rush and impatience among patients.

iv) Lack of proper examination – patients feel that they are not properly examined and that is why they prefer private doctors resulting in the mushroom growth of Nursing homes and private practitioners.

v) Doctors lack social conscience – Doctors do not have concern for social justice, compassion for underprivileged. There is lack of strong commitment and spirit of service, vital for the success of medical profession.

vi) Discourteous behaviour

vii) Non – availability of medicine.
viii) Fear of hospital infection because of poor cleanliness.

According to table no.7.8 (chapter-7 survey observation) in all three clusters (A, B and C) 79.7% respondents found the availability of doctors in OPD as unsatisfactory. This reflects the size of this problem in the government hospitals similarly while inquired on stress for private consultancy table 7.9 (chapter-7 survey observation) 82% complained of doctors stressing for practice again when the behaviour of doctors and other staff was inquired 70.7% was unsatisfied on this issue. While asked about delay in investigation and check up table no. 7.11 (chapter-7 survey observation) 78.4% respondents complained of delays and wastage of time and slow working, working gaps and disruptted work. Once again while question on the availability of medicine 51.2% respondents of three cluster together replied in negative even those who were provided medicine by the hospital complained of inadequate, inferiors quality and delays in obtaining these medicines. Many of them levied corruption charges on this count also.

• **Indoor patient**

Indoor patients in the various test hospitals of cluster ‘A’ ‘B’ and ‘C’ highlighted followings problems during the inquiry.

(a) Shortage of beds and wards

(ii) Poor nursing and caring facilities

(iii) Poor quality, less quantity malnutrition fooding facility
(iv) Lower degree of cooperation by staff.

(v) Inadequate Building poor sanitation, inadequate facility of electricity, inadequate facility of drinking water.

(vi) Shortage of washroom etc.

According to table no. 7.13 (chapter-7 survey observation) in all three clusters (A, B and C) 78.8% respondents found the availability of beds and wards as unsatisfactory. Similarly while inquired on nursing and caring facility table 14 (chapter 7 survey observation) 76.2% complained of nursing and caring facility when the feeding facility was inquired 77.9% (table no. 7.15) respondent in all clusters was unsatisfied on this issue. When the respondents were examined on the issue of cooperation of doctors and other staff only a very small percentage of 2.6 termed as good and 76.5% found it unsatisfactory while 18.8% found it satisfactory. This indicates that about 4/5 respondents complained on this issue of infrastructure namely Building, sanitation, electricity, drinking water etc. 75.3% found building facility as inadequate, 78.2% found sanitary facility as unsatisfactory, 78.6% found electricity facility as inadequate, 79.4% found shortage of drinking water facilities and 81.5% found washroom and toilet facilities etc. as inadequate.

- **Attendants**

An inquiry into the problems of the attendants of patients reveal that there is a shortage of staying facility in the hospital campus.
only in private wards attendants were allowed to stay with the patient while in General ward only 1 attendant is allowed at a time and merely a bench is provided to sit on to look after the patient even during the night. This encourages them to sleep in the corridor or ground of ward itself which exposes a high risk of infection in them. Similarly sanitary facility and drinking water facility were not adequate and that is why 74.3% of the respondents expressed their dissatisfaction on these issues.

**Hospital Staff**

During the survey of cluster hospital the staff was categories as

i) Doctors

ii) Supporting staff

iii) Office staff & helper

iv) Class IV employees

During the course of inquiry on working condition 15 (50%) out of 30 doctors, 35 (58.3%) out of 60 supporting staff, 11 (52.38%) out of 21 office staff and helper and 35 (58.3%) out of 60 of IV class employee found it unsatisfactory. They complained of long working hours, low pay package, political interference in the working. They found working environment including hygienic condition as unsatisfactory.

When the above four categories of employees were asked to comment on promotion and future. Prospects 19 out of 30 doctors, 33 (55%) out of 60 supporting staff, 12 out of 21 office staff & helpers and 38 (63.3%) out of 60 IV class employee were
dissatisfied on this issue they complained of slow and lesser promotion avenues and also interference of politicians and favourtism by their superior officers.

When these employees were inquired on the training facilities 15 (50%) out of 30 doctors, 33 (55%) out of 60 supporting staff, 12 (57.1%) out of 21 office staff and helper, 35 (58.3%) out of 60 IV class employees complained of lack of training facility and favourtism in sending the employee for training. On the issue of career development 19 (63.3%) doctors out of 30, 32 (53.3%) supporting staff out of 60, 11 (59.38%) office staff & helper out of 21 and 33 (55%) class IV employee out of 60 were highly unsatisfied.

It is clear from the comments of the respondents that majority and all type of employees were highly unsatisfied for one reason or the other.

• **General Public/ Visitors**

During the course of survey an attempt is made to gether the view of general public/ visitors (both male & female) on the various facilities available to them in the hospital like visiting hours or meeting hours, infrastructure and sanitary facility etc. In all cluster combined 73.6% of respondents were dissatisfied over the facilities for which they were asked to comments.

The researcher is of the view that a very high percentage of all the type of respondents under inquiry were highly unsatisfied on the various issues.
8. PROBLEM OF OUT SOURCING

The Government hospitals are facing a big problem of reliability and certainty of the result of pathology tests, and x-ray etc. For this reason the government doctors also encourage the outsourcing of these services in private sector. It is often seen that both in the eyes of doctors and patients the results drawn by private pathological tests are considered more reliable. This not only encourages the private participation in government hospitals but also sometime develop a feeling that the capital investment by the government in pathology lab etc. and the running cost of the same has become waste full expenditure. At small hospitals these facilities sometime even do not exist and the patient is bound to depend on out sourcing these facilities.

Out sourcing of these services have also encouraged corruption as clinics and labs supplying these services offer a commission to the doctors concerned for encouraging the patient to get these tests conducted from these clinics etc.

9. OTHER PROBLEMS

• Inadequate PHC Building

All the Primary Health Centers are functioning in buildings whether Government or rented which have limited available space. Besides there is in sufficient availability of residential accommodation in remote rural areas, which is acting as a great deterrent in motivating medical officers to work in such areas.
• **Medicines and Equipment**

The supply of medicines and equipment was inadequate in most of the health centres due to the paucity of resources. Besides, there was no regular supply. The stock of medicines was inadequate in all the centres.

• **Insufficient Administrative Powers of Medical Officers**

For efficient functioning of the centres, the administrative powers should be decentralised. The Medical Officer of the PHC is supposed to be the planner, the manager, the supervisor, the coordinator as well as the Public Relation Officer, besides being a technical expert. Is he well equipped to discharge all these functions entrusted to his care? At present, all the incumbents possess no administrative competence which is essential to administer the PHC complex.

• **Vacant Posts Need to be Filled**

The number of patients are increasing everyday with an increase in population. On the contrary to this the number of doctors and other staff is decreasing due to the fact that. Many of them have retired. Government has taken no concrete steps to fulfill them. This has disturbed the doctors patients ratio in the hospitals. Low doctor patient ratio causes negligence by the doctors towards their attention for patients.

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