Organisation and Administration for III
Members of modern societies obtain a large part of their material, social and cultural satisfactions from large-scale governmental administrative organisations. Following Parsons, organisations could be defined as social units which are predominantly oriented to the attainment of specific goals. Gans adduces a more pervasive description of an organisation in stating that it is the arrangement of personnel for facilitating the accomplishment of agreed purpose through the allocation of functions and responsibilities. Viewed in this light, formal organisation is the structural aspect of rational action. The mobilisation of technical and managerial skills requires a pattern of co-ordination, a systematic ordering of positions and duties which define a chain of command and make possible the administrative integration of specialised functions.

Thus, while 'development' and 'modernity' constitute the primary ends of a developing country 'administration' and organisation are the means for achieving them.

Administration can be defined as a process of functions: it is planning, organising, leading and evaluating processes to achieve specific ends. The goals are determined in the planning function. Allocation of scarce resources is the principal factor in both planning and organising. Leading involves the primary managerial task of achieving the goals through people. Finally, evaluating function reviews performance against the established goals and if necessary initiates corrective action. Organisation is the establishment of relationships between activities to be performed, the personnel to perform them and the physical framework that delineates the specific area of operation. It provides the formal structure of authority and task relationships to co-ordinate human efforts to deploy the available resources and to foster the effective and efficient attainment of goals.

Frederick Taylor outlined five basic propositions, which taken as a whole, reflect on the propositions for "the best of modern administrative machine." (1) Administration is a complex process through which administrators attempt to guide the activities of people within organisations toward the achievement or formulation of an accepted pattern of purposes. (2) Organisations have multiple purposes which receive different degrees of emphasis by different members with the purposes
being in constant pattern or change in response to new situations. (3) Conflicts, obstacles or changing circumstances within organisations or between the environment and the organisation block the achievement and formulation of such purposes. (4) Blockages are coped with when administration and organisations develop, maintain and use power or influence with varying degrees of responsibility and authority. (5) Administrators use or engage in a variety of practices while dealing with the organisation and its environment, including various technical, administrative processes relating to budgeting, research, personnel, distribution of output, planning and evaluative processes and the general process of decision making and communicating. Thus the modern approaches to administration of organisations rest on the fundamental proposition that "nothing human is alien to administration."

The administration of modern organisations involve a confrontation of the administrator with a variety of short and long range problems requiring a multitude of prescriptions. The general task of reconciling the behavior of workers with the goals and objectives of the organisation requires the instrumentation of various processes by which leadership is formed and maintained, communication is carried on, workers motivated and various strategies of administration executed as changes occur.

This chapter studies the structure of health care delivery in ramilndu from those perspectives. Effective administration of health care requires an integrated interaction between formal, and informal organisations on the one hand and between the formal organisation and the external environment on the other. In the modern context of welfare state, especially in a developing milieu which demands maximum governmental involvement, the attainment of health policies depends on the prevalent cultural norms and values. Therefore, no specific administrative pattern could be applied in toto.

However, historically speaking, the departments, constitute the most fundamental and direct organisational structure for governmental action. It is here that the arms of the executive branch reach out to render services to the citizens. The department is a unique organisational factor that blends the administrative and functional processes at all levels of governmental activity, especially in the sphere of welfare services. Thus, it is one of the most popular structures of public administration in most developing countries especially in the execution of social and public utility services like the delivery of health care.
The administrative significance of the departmental system is that it enables an integrated approach. An attempt is made to group all services whose operations fall in the same general field and which should consequently maintain intimate working relations with each other, into departments presided over by officers having a general oversight of them all and entrusted with the duty of seeing that they work harmoniously towards the attainment of the common end. The advantage in the departmental type is that by grouping the related activities under a single governmental authority, they are brought into close relationship and co-ordinated with one another. The line of authority runs from the several services to the departments of which they are the units and from the department to the chief executive - the minister or to the legislature whose jurisdiction extends completely over a department or all the departments.

In Tamilnadu, as at the federal level, the department has been the organisational framework for the execution and attainment of all public health activities and goals.

Health organisation at the state level:

The health and family welfare department, which is the integrated unit consisting of the health ministry, the Health Secretariat and the functional units or the Directorates is headed by the minister who is of the cabinet rank and is the highest policy and decision-making authority regarding all the health matters in the state. The minister being the highest authority in the departmental system of organisation, the minister has to perform the functions of both political head of the ministry and the executive head of the department.

As a member of the legislature and as a minister in full charge of the health portfolio, he consolidates and co-ordinates the political aspects regarding all the health issues, including various shades of public opinion, introduces and guides the health bills to acquire legislative approval within the framework of the total policies of the Government.

As the executive head of the department, he ensures the implementation of the policies approved by the legislature and exercises supervision over the entire administrative machinery involved in its implementation.
The predominant 'staff' function of advising and assisting the minister is performed by the 'Health Secretariat' which is attached to the ministry and is next in line of authority. The Health Secretariat is an integral part of the State secretariat which refers to a complex of departments which assists the state administration to keep a record of the policies framed by the political heads and to watch over their implementation and execution. The secretarial organisation is headed by an officer of the Indian Administrative Service of the rank of Commissioner and Secretary who functions as Secretary and Commissioner to the Government in the Department of Health and Family Welfare. He is assisted by 3 Deputy Secretaries and 4 Under Secretaries. The twelve sections under the section officers deal with various branches of health services and provide all the infra-structural services at the policy making level.

The main duties and responsibilities of the Health Secretariat are: generally policy-making and co-ordination operationally the responsibilities of this apex body are split into:

1. assisting the minister in policy-making, modifying the policies in keeping with the changing circum-

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stances and duties and in the discharge of his legislative responsibilities,

2. framing draft legislation, rules and regulations covering the entire gamut of health activities;

3. budgeting and control of expenditure;

4. maintaining relations with the Centre, other state Governments and international health services and agencies; and

5. overseeing the smooth and efficient running of the administrative machinery and initiating measures designed to develop greater personnel and organisational competence.5

Below the 'Health Secretariat' are the executive directorates that bring to bear technical expertise and skills on the administrative and policy-making levels in public health and medical services. The 'Directorate' is an administrative unit separate from the secretariat, though under its administrative supervision, and the Director officiates over it as the single administrative head. The Directorates are

headed by specialists and are concerned with the supervision co-ordination and execution of the policies framed by the government.

The health services in the state may be classified into three major categories namely medical education, medical services and public health. These, as present, are executed by five directorates, viz., Directorate of Medical Education, Directorate of Medical Services, Directorate of Indian Medicine, Directorate of Public Health and Preventive Medicine and Directorate of Primary Health Centres. All the five Directors function under the authority of the Department of Health Services and Family Welfare.

To present a brief historical perspective, the origin of public health of Tamil Nadu can be traced to 1864 when the Sanitary Department was established in the erstwhile Madras State. The responsibility and the credit for establishing the health administration in the state on a firm foundation goes to the then British Imperial rulers.

Health activities were, however, started under the aegis of the military in the British Cantonment areas. Thereafter the need to improve the 'civil native' health conditions was
highlighted by the Royal Commission which functioned from 1853 to 1863 after which the Sanitary Commissioner was appointed in 1864 to advise and assist the Government of Madras in all matters relating to public health in supervising the sanitary improvement of the native towns and in surveying the prevalence, causes and means of preventing diseases. In 1869, the Sanitary Commissioner who was till then with the military department was transferred to the Civil department.

1865 marked an important development in the 'preventive' aspect of public health in the state. The Vaccine Department, which was started even in 1802 was thoroughly reorganised and by 1878, the Inspector of Vaccination was redesignated Inspector of Vaccination and Deputy Sanitary Commissioner.

1883 witnessed the evolution of the District Health administration through the appointment of "Zillah" or district surgeons as medical and sanitary officers. Their duties included advising and assisting the respective District Collectors in matters affecting the medical and sanitary administration of the district and to mobilise the local health personnel. They were to inspect as frequently as was consistent with their other duties, the minor dispensaries in charge of subordinates and the working of the vaccine and conservancy establishment of the district.
Another landmark was the first attempt made to register the mortality rate in the Presidency in 1863 through the agency of the sanitary department. This has now developed into the vital statistics section of the Public Health Department. Another important happening in this sphere was the passing of the 'Madras Registration of Births and Deaths' Act of 1889.

The early years of the 20th century witnessed a renewed activity in preventive medicine. The Government established cholera parties in 1912 for cholera detection and preventive work consisting of 10 sanitary inspectors, each party was put under the direct control of an assistant surgeon. The Government established a total of 8 such parties over the next decade. In 1915 the first Presidency Pilgrimage Committee was set up to supervise and ensure health facilities in all centres of pilgrimage in the state. In 1920, the Malaria Board was amalgamated with the Public Health Board under the direct control of the Minister-in-charge of Public Health.

The year 1922 proved to be a watershed in the history of public health in the Presidency. It heralded the birth of the modern public health department. In accordance with the Government of India Act 1919, which transferred the subject of 'Public Health' to the provincial jurisdiction, the title of
'Sanitary commissioner' was changed to the 'Director of Public Health'. The department of Public Health was reconstituted in 1923 for the improvement of the general health conditions in the State and for the prevention and control of communicable diseases.  

The government authorised 'Public Health Code' was sanctioned in 1924 and completed in 1927. This code still remains as the most important document to guide health administration in the state.

The year 1939 marked the beginning of a very significant era with the passing of the Madras Public Health Act. This was the first of its kind in the country and has been the foundation of subsequent legislation and administration of public health in the state till the present day.

When India attained Independence in 1947, State and District boundaries were reorganised and development schemes to afford medical and public health subsumed under the Five Year Plans. Though 'Health' was constituted under the 'State' list of the Constitution of India, the Central Government has been giving leadership and direction in organising and implementing several health programmes. Since Independence,

rural had to along with the rest of the country begin to
experience the trauma of drastic political and social changes
resulting in the generation of varied problems relating to
health for which the major causes were the growth of population,
of this population, migration to urban centres, industrialisation leading to
problems of environmental sanitation, concentration of medical
technology in the urban centres and more and more of rural
population especially vulnerable sections like women and
children becoming more exposed to communicable diseases.

After the first general elections in 1951, a separate
ministry of health was formed in Tamil Nadu with a minister of
Cabinet rank with an exclusive portfolio for health. This
ministry took charge of all matters concerning the policy-
making, planning and administration in the sphere of public
health and medical services. The Medical and Public Health
Departments functioned as independent departments till 1966
when they were integrated and reconstituted to form a separate
Directorate of Health Services and Family Planning. At the
same time the control and direction of medical education,
training, administration of all training institutions as well
as teaching hospitals were vested with the Directorate of
Medical Education. 7

7. Brochure of Rural Health, Directorate of Public Health,
Tamil Nadu, 1978.
After a period of integration for 10 years from 1966 to 1976, medical services and public health were separated and made independent departments again. The Department of Public Health now functions as the 'Department of Public Health and Preventive Medicine'. This is indicative of the increasing importance accorded to the preventive aspect of public health. On the curative side, the Government established a separate Directorate of Medical Services and Family Planning, having control over all the state, district and taluk headquarters, hospitals, and dispensaries.

Thus all preventive public health activities and services are executed by the Director of Public Health and Preventive Medicine (DPH & Pm). The DPH & Pm is responsible for planning and formulation of various programmes for the development of public health, especially for the control, prevention and eradication of communicable diseases. Till 1980 this Directorate was in-charge of the administration of the Primary Health Centres in the State. However, in recognition of the intensity and importance of primary health care, the functions relating to the static components of primary health centres, the mobile health teams and the organisation of mini health centres were handed over to a new unit, namely the Directorate of Primary Health Centres (DPHC).\(^9\)

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8. G.O.M. No.2749, dated 21st October 1976
These two directorates render all specialist and technical assistance to the Health Ministry and the Health Secretariat in all matters relating to public health and primary health care services and provide technical leadership in planning and co-ordinating all the health programmes.

The Director of Public Health is assisted by officials along with doctors and specialists in different areas of public health. While the Director controls and co-ordinates the overall functioning of the department, there are two Joint-Directors in-charge of nutrition programme and malaria respectively and two Deputy Directors in-charge of training and prevention of food adulteration respectively. The next level of administration consists of Assistant Directors who may be classified into functional and regional officials. The former are put in-charge of specialised health programmes covering the entire State, while the latter exercise general administrative control over a particular area. A total of four functional Assistant Directors are attached to the Directorate of Public Health handling individual subjects, namely, Maternity and Child Health, Health Education, Epidemiology and Immunisation and Nutrition respectively. A fifth Assistant Director, though a non-medical person, is a qualified statistician and is in-charge of the collection and management of vital
statistics for the whole state. The Chief Accounts Officer handles all the financial and budgetary aspects of the directorate. An administrative officer holds charge of the establishment, general administration and clerical functions of the directorate. 10

The Directorate of Primary Health Centres, the most recently created establishment, is headed by an independent Director assisted by a Deputy Director. The major responsibilities of this directorate include the appointment of Medical Officers to all the Primary Health Centres in the State and co-ordinating all the health programmes that emanate from the Primary Health Centres. 11

This is a singular department that has been created for the first time in the country for the exclusive management of primary health centres.

With regard to organisational structure, personnel and method of administration, the areas of preventive services which comprises almost all the public health activities are separated from the curative or clinical services which include all the medical and family welfare activities.

Health Organisation at the Regional and District Levels

The significance of district health organisation was forcefully expressed by the More Committee which perceived the district as a convenient basis for organising local health administration. It stated that the district health organisations should be under the control of an officer responsible for curative and preventive health functions in the area. It also suggested the formation of the District Health Council consisting of experts to provide the technical advice and guidance to the Board in the promotion of various health programmes.12

This brief description clearly presents the comprehensive features of the local health administration namely, the dual approach – curative and preventive and community participation. Two vital requirements of the district health pattern are that the peripheral units of the organisation should be brought as close to the people as possible and that the services rendered should be sufficiently comprehensive to satisfy modern standards of health administration.

the present regional and district health structure in Tamilnadu is considerably different from what was envisaged by the Bhore Committee, although the difference lies more in matters of form and detail rather than spirit and endeavour.

The primary objective of social development administration is that bulk of the information and the processes for policy-making and policy-implementation should emerge from the local clientele themselves. This has been the basic policy of district health administration in Tamilnadu. Accordingly, the state now consists of seven health regions, each headed by a Regional Assistant Director of Public Health and Preventive Medicine with jurisdiction over two or three revenue districts. This was effected in March 1981 and was the first reorganisation at the regional level attempted by the State health department with a view to effect greater decentralisation and closer co-ordination of health activities at the district level.13

The Regional Assistant Director is responsible for co-ordinating the health activities in the districts within his jurisdiction and for supervising the implementation of the

various health programmes. He reviews the progress of the health programmes at the divisional level and takes such measures as may be necessary to rectify the defects and effect improvement. He exercises technical control over the food analysis laboratory and District Health Officers in the respective regions. One important responsibility of his is to plan at the micro-level for the effective implementation of the health policy and programmes.

The sixteen revenue districts of the State are divided into twenty-nine health unit districts. The District Health Officer (DHO) is the head of the district health administration and the most important health functionary in the district. His importance gains significance from the fact that he is the principal liaison between the state headquarters, i.e., the directorate and the local units namely the primary health centres. The DHO co-ordinates, supervises and implements the various health programmes in the respective districts and is authorised to exercise full executive authority in all public health matters in the district. 14

14. Tamilnadu Public Health Act (Revised), Government of Tamilnadu, 1939, p.16. Vida Appendix III for the names of health districts and the number of PHC in each
The eradication of malaria has been given special importance and under the national malaria eradication programme, each district possesses a district malaria Officer for exclusive malaria eradication activities. The State is classified into five exclusive malaria zones with a zonal officer in-charge of each zone to supervise district malaria officers.

The present district health structure is based on the division of each district into blocks. This was introduced in 1957 for administrative convenience. A block consists approximately of 70,000 to 80,000 population and about 100 villages. The allocation of one block is made in two stages, the first of which lasts for five years before entering the second stage or what was formerly known as 'post-intensive Blocks'. During the stage I period, the State Government plans and formulates an integrated programme, which includes location of the block headquarters, preparation of building plans, recruitment of staff and training. This period is of great value for the planning of health services, as it provides the health administration both at the state and the district levels sufficient time to organise a quick survey of existing health activities, health needs and health problems of the area and also the time to review the staff requirements and the training procedures.  

15. Primary Health Centre, Department of Community Development, Government of India, New Delhi, 1960, p.2.
Each block is served by the most vital unit of the health organisation namely the primary health centre (PHC) which offers a package of curative and preventive services to the population in the block area with in-patient and out-patient facilities and also organises various community health services. The last and the smallest field unit of the district health structure is the sub-centre. The sub-centres are attended to by the staff of the PHC. They are more of a micro-level paramedical institution catering mostly to the maternity and child health needs of the village community. Each primary health centre is attached with sub-centres at the rate of one for 5000/10000 population within the block area. The PHC acts as a technical adviser on matters of health to the local bodies such as the Panchayat Union Councils or the Block Development Councils. It constitutes the nucleus public health institution from which all the curative and preventive activities emanate and also serves as a research centre to study the health and medical problems in detail and to seek viable solutions. Above all the PHC is a focal point of a referral system operated by maintaining regular contacts with the district and taluk headquarters hospitals.

The principal aspect of the PHC is accessibility to the rural population. Thus the location of the PHC is decided by
the Block Development Committee in consultation with the
district medical and health officers. The Government, moreover,
applies certain general criteria in selecting the site such as -

1. health needs of the area as indicated by a
detailed survey;

2. extent of participation of the people in the
form of land and contribution towards capital expenditure;

3. easy accessibility and facilities for communications and transport; and

4. accessibility to referral hospitals with adequate
equipment and specialist service.

In all there are 376 Panchayat Unions in the State, out
of which 374 are provided with a PHC. Besides nine unions have
been provided with an additional centre. Two additional centres
were established under the 'Hill Area Development Programme'
in the Nilgiris district. There are altogether 405 PHCs
currently functioning in Tamilnadu. 16

16. Policy Note on Public Health, Government of Tamilnadu,
1982-83, p.2. Vide Appendix IV for the list of PHCs.
Of the 405 centres, 192 are functioning in government buildings, the rest function in rented buildings. The government either purchases them or puts up new structures, depending on the availability of finance, in a phased manner. As per the Alma-Ata declaration of 'Health for All by 2000 A.D.', and the more committee objective of establishing on primary unit for a population of 40,000 to 50,000 and considering the rate of population growth, Tamil Nadu will need 740 PHCs by 2000 A.D.\(^{17}\) The government has already started moving towards this objective by sanctioning 20 additional centres with necessary staff and equipment during the year 1982-83.

The smallest unit in the health delivery structure and which is no less significant a field unit than the PHC is the sub-centre which is manned by the auxiliary staff of the PHC. The location of the sub-centres as in the case of the main centres is subject to certain conditions which state that—

1. The villages should be so grouped, that the population to be served by each sub-centre should not exceed 5,000;

2. The area of the land for the sub-centre should be 675 sq.m. or 7,200 sq.ft.;

\(^{17}\) Performance Budgets, Public Health & Preventive Medicine, Government of India, Tamil Nadu, 1982-83, p.15.
3. as far as possible, the village where the sub-centre is to be located should be at the centre of the jurisdiction it has to cover;

4. as far as possible no person should have to travel more than three-fourths of a kilometer to reach the sub-centre;

5. the site should be in a scheduled caste or scheduled tribe area or at least contiguous to such areas;

6. it should be located near a water source as far as possible within half a kilometer distance with a perennial supply of at least a minimum of 500 gallons per day;

7. as far as possible, the villages with electric supply should be chosen;

8. the site should be on elevated ground with natural drainage and areas subject to flooding must be avoided at all cost;

9. the land acquired for locating the sub-centre should be free from all legal encumbrances, such as mortgage lease etc., and
10. The site should be so selected, that the sub-centre building faces south or at least should avoid north-west position to avoid heat radiation.18

The significance of the sub-centre is that it serves as the personal point of contact between the basic health staff of the PHC and the population. The health personnel reach to population in their houses to establish a personal rapport and the services rendered are based on an intimate interaction and is time-bound, covering a wide-range of health activities including the individual, the family and the environment, rather than mere diagnostic treatment. At present there are 3390 sub-centres in the state attached to the Primary Health Centres. All the sub-centres are maintained by the Government. The sub-centres could be classified as follows;

a) Maternity and Child Health Centre under the Backward Area Scheme 76

b) Sub-Centres under the Institute of Health, Poonsamallee 8

c) Sub-centres in tribal areas 2

d) Additional sub-centres established under multi-purpose health workers scheme.

c) Panchayat union sub-centres brought under the charge of the health department.

Total: 3,360

The government has sanctioned the establishment of another 527 sub-centres in 1981-82. 19

The medical officer of the primary health centre is the administrative and technical authority in full charge of all the health activities within the block area. He, therefore, not only attends to the clinical functions as the PHC, but also supervises and co-ordinates the fieldwork of the public health staff attached to the centre. The staff pattern of a primary health centre is as follows:

Medical Officers - 3
Pharmacists - 3
Male nursing assistants (M.N.) - 1
Auxiliary nurse midwife (A.N.M.) - 1

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General Health Inspector - 1
Health visitors - 1
Basic health workers - 5 to 8

Each PHC possesses a contingent of family welfare staff consisting of -

Auxiliary Nurse Midwife - 1
Basic health educator - 1
Health Visitors - 1
Health Inspectors - 2 to 3
Computer - 1
Store Keeper - 1

The Health Inspectors, auxiliary Nurse Midwives, Health Visitors and Basic Health Workers constitute the field staff of the PHC. They assist the Medical Officer in carrying out health surveys, collecting and consolidating health statistics, attending to the environmental sanitation of the Block, control of communicable diseases and the development of Maternal and Child Health services in the Block. It could well be stated that the Primary Health Centre constitutes the very kernel and the most vital component in the entire health organisational structure.

the hierarchical pattern of the health organisation at the state and regional levels is presented below:

<table>
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<tr>
<th>Health Ministry</th>
<th>Health Secretariat</th>
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<tbody>
<tr>
<td>Directorate of Public Health and Preventive Medicine</td>
<td>Directorate of Primary Health Centres</td>
</tr>
<tr>
<td>Regional Assistant Directors of Public Health &amp; Preventive Medicine</td>
<td></td>
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<tr>
<td>District Health Office</td>
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<tr>
<td>Primary Health Centres</td>
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</tr>
<tr>
<td>Sub-Centres</td>
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</tbody>
</table>

Institute of Public Health:

This institute was established in the year 1935 with the help of the Rockefeller Foundation, as an exclusive institution for the improvement of rural health activities. The primary objectives of the Institute are to work an intensive experimental health scheme in order to demonstrate and measu
their efficiency and also to conduct training courses for medical and para-medical workers in all aspects of public health.

In 1966, the three wings of this unit, namely, the Health Unit, the Orientation Training Centre and the Research-cum-Action Project were amalgamated to form the service, training and research wings of the 'Institute of Public Health' under the Assistant Director of Public Health and Preventive Medicine. The Institute has now expanded its operations to provide health education training to school teachers and other social service personnel.

The Institute covers an area of 62 sq. km. with a population of 1,28 lakhs and 39 villages. One of the most significant projects of the Research-cum-Action wing of the Institute is to provide sanitary-toilet systems in rural areas where there are no drainage or sewerage facilities. This is an important scheme in the enhancement of environmental sanitation in rural areas. 21

The organisational structure thus provides a framework with a rationally related set of officers and designations. This structural framework enables the mobilisation of the required personnel with the required qualifications, skills and training and takes up the responsibility of promotion of public health in dalamadu.

Personnel administration:

The administrative process constitutes the operational element of the organisational structure, thereby making the administrative organisation a significant blend of two vital endeavours in the social welfare development of society and more specifically in public administration. The process and concept of administration has been expounded by various theorists with classifications ranging from the 'traditional modified' to the bureaucratic phenomenon. However, the primary objective of the administrative organisation is the achievement of purpose. The important characteristics of administration in terms of this objective can be reduced to three from amongst an extensive list: (i) hierarchy, (ii) differentiation, and (iii) manpower. Hierarchy is probably the most important because it is closely associated with the effort to apply

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rationally to administrative task and identity that ensures a firmly ordered system of superordination and subordination in which the higher offices supervise the lower ones. This interlocked system of relationships provides direction, cohesion and continuity to the administrative process. Specialisation is the result of the division of labour which is a prime requirement of any co-operative human endeavour to reach complex goals. The specialised allocation of tasks leads to the emergence of 'roles' with a specific purpose for each in terms of responsibilities and areas of action. Manpower is perhaps the most significant and pervasive feature, referring to the entire personnel component that constitutes the 'human material' of the administrative organisational system in terms of the persons playing organisational roles. It is required that each person in the organisational structure be qualified and trained adequately. Commonly referred to as 'personnel administration', it subsumes almost all the elements of administration which includes leadership, delegation, morale, control, authority, methods and procedures with reference to the positions and their relationships. L.D. White aptly refers to personnel as the sovereign factor in public administration.


'Health' in the modern welfare milieu is oriented towards development administration, which emphasizes a shift from the 'executive administration' of merely implementing the laws to 'managerial administration' which is programme oriented. This requires the administrative structure to imbibe development values in keeping with the prevalent socio-cultural dispensations and to achieve the welfare objectives programmatically. 'Health' is one of the crucial areas of development administration wherein the objects of the organisational structure and the administrative process are not merely to implement certain stated health goals, but to generate social consciousness concerning environmental hygiene and its influence on the individuals health through active community involvement.

This trend is more accentuated in the area of primary health care delivery.

Position Classification of the Public Health Department:

The entire complement of personnel under the Directorate of Public Health and Preventive Medicine in Tamilnadu is classified under the Tamilnadu Health Services.

The responsibilities of the Directorate of Public Health and Preventive Medicine and the Directorate of Primary Health

25. Vide Introduction to this thesis.
Centres involve different functions in the same area of activity namely the prevention and control of communicable diseases and the improvement of the general health condition in the State. 26

Public health manpower cadres in the state are divided into vertical and horizontal groupings. The vertical division involves the hierarchy of technical personnel which includes doctors, statisticians, nursing personnel, pharmacists, health inspectors, health visitors and health workers. Except for doctors and certain non-medical personnel, the other categories are grouped together as para-medicals. Each of these vertical groupings can also be divided horizontally into professional and auxiliary levels. The professional is trained and educated in highly technical spheres of medical and health sciences to internationally accepted standards. 27 The registered medical practitioner is the only cadre in public health who is categorized as a professional. The professional cadre is also in-charge of administration and occupies top and middle management posts both at the headquarters and in the districts. The auxiliaries are those with fewer years of technical education and training involved in all para-medical areas of activity.

Thus the administrative hierarchy is composed of both medical and para-medical professionals. The Director of Public Health and Preventive Medicine is the chief Health Administrator and the senior-most member of the State Health Services. He is in overall charge of all the offices in the Public Health and Preventive Medicine in the State and supervises the planning, formulation and implementation of various programmes for the development of public health activities, control of communicable diseases and prevention of food adulteration. The technical competence and the administrative ability of the Director play a crucial role in the effective administration of health care in the State. He is the most important decision-making authority regarding both administrative and technical issues.

The two Joint Directors who are next in line of hierarchy occupy functional posts. They are in respective charges of two functional areas of operations, namely, Malaria and the integrated nutrition projects. They are followed by the two Deputy Directors again with functional responsibilities, in-charge of the integrated nutrition projects and the food cell respectively. These officials are thus in-charge of exclusive specialised areas of operation. Though they exercise general supervision in these areas and monitor the respective specialised programmes

they serve more as technical advisers and expert consultants to the Director in all matters concerning these special fields of operation. The Joint and Deputy Directors are thus more of full-time professional advisers in their respective spheres.

The third line of command at the state level consists of the six assistant directors, all of them are functional authorities in exclusive charge of a specific programme. They plan, design, monitor and consolidate all the activities under the respective programme throughout the state. The representation of a particular specialised area of a programme in the hierarchical line of the state administration denotes the priority and importance accorded to it. Thus Malaria control and nutrition programmes are accorded top priority by placing them under the charge of two top administrative levels of the hierarchy.

An extension of the third line of the hierarchy is the position of the regional assistant director. This is a decentralised general administrative post. The Regional Assistant Directors are in-charge of all the health activities in the districts that comprise their respective regions. Their primary responsibilities are to exercise closer supervision on the comprehensive health care delivery in the field and expedite the process by facilitating faster and better communication with the field staff and health units at the district and block-levels.
The principal component of such decentralised field organisation is 'delegation of responsibilities' to the field units from the superior office. However, the Regional Assistant Director has not been vested with any real powers. His responsibilities are not well delineated except in general terms. He does not possess any authority to make postings, effect transfers or take any disciplinary action. Thus in operational terms he acts merely as a liaison between the District Health Officer and the Directorate.

The District Health Officer is the most important 'Line' health functionary in the district and is a qualified doctor with public health training. The DHO is the real authority in all matters concerning health care delivery in the districts in areas both administrative and technical. He exercises complete supervisory authority over all the Primary Health Centres including the appointment of all the auxiliary personnel. He co-ordinates the health activities with all the developmental activities of other departments and non-governmental agencies in the District. In other words, he exercises the power of the Director within a restricted framework.

The Medical Officer is the last 'line' functionary at the block level. He is in full-charge of the Primary Health Centres. The Medical Officer is the key health-care medical functionary in the block. As each Primary Health Centre has two or three Medical Officers, the senior-most amongst them officiates over the Primary Health Centre and is designated Medical Officer-in-charge. The Medical Officer-in-charge exercises full control over the entire complement of the staff of the Primary Health Centre. However, the Medical Officer is also a curative personnel. He attends to the clinical work of diagnosing and treating patients both at the Primary Health Centre and in the villages during his tours with mobile health units.

However, the Medical Officers come under the supervision of the Director of Primary Health Centres who appoints them and exercises general control over the functioning of the Primary Health Centres. But the Director of Primary Health Centres has no authority over any other staff of the Primary Health Centre. This is a notable area of ambiguity in the field of health administration.

Most staff of the Primary Health Centre can be classified under the 'auxiliary grouping'. This group is involved in
assisting the medical officer at the Primary Health Centre in attending on patients. However it is mainly concerned with implementing the various control and preventive programmes emanating from the Primary Health Centre. The most significant public health responsibility of the auxiliary staff is to establish and maintain close contact with the community in providing immediate and simple health care. The auxiliary staff of the Primary Health Centre fit into the following hierarchy below the medical officer:

1. Health Inspector
2. Pharmacist
3. Health Visitor
4. Auxiliary Nurse Midwife
5. Male Nursing Assistant
6. Vaccinator and Health Worker

The ministerial staff consists of the cook-cum-waterman, and other menials. A key health worker cadre is the Public Health Health Inspector who cannot be generally classified under the auxiliary staff. The primary task of the Health Inspector is the policing of sanitary conditions in the town and villages and such places as the public markets and other such establishment supervising the maintenance of health conditions and health

standards. He is a non-professional health supervisor who assists the medical officer in carrying out health surveys of the villages in the block. On the basis of the survey, the medical officer plans out a programme with the health inspector responsible for its execution. Being in full charge of maintaining the environmental conditions, he is also responsible for carrying out measures for the control of communicable diseases under the instructions of the medical officer. In fact the health inspector is an important health personnel in charge of the overall environmental sanitation programme in the block. The other auxiliary and para-professional personnel who are attached to various projects and schemes include:

1. Food Inspector
2. Statistical Assistant
3. Health Assistant
4. Unclassified Assistant

Recruitment and training:

Inducing the right person with adequate skills and qualifications to perform specific functions by occupying specific roles is the primary objectives of recruitment. The major system followed predominantly in the modern welfare era of equal opportunities is the merit system. This in short means a system in which the appointment and conditions of service of an employee are determined solely on the basis of his own intrinsic merit - which includes his educational and technical qualifications, personal capacities and physical fitness. Most recruitment to the health departments are made through the two general personnel agencies, namely, the Employment Exchange and the Tamilnadu Public Service Commission.

The post of the Director is an independent one with the appointment made directly by the government. But conventionally the incumbent is the senior-most member of the State Health Services who ascends the hierarchy through promotion. The District Health Officers are selected by the Tamilnadu Public Service Commission and are appointed by the Director. The District Health Officers are qualified medical practitioners with a diploma in Sanitary Sciences. Immediately on appointment they are given a three months in-service training in public
health at the Institute of Public Health, Coimbatore before being posted to the districts. The District Health Officer by virtue of experience is promoted to the posts of Assistant, Deputy and Joint Directors.\textsuperscript{33}

Amongst the auxiliary staff, the Health Inspectors are appointed through the Tamil Nadu Public Service Commission. They are required to undergo a one year 'Sanitary Inspector's Course conducted at the Madurai, Stanley and Chinnarput Medical Colleges and at the Gandhigram Rural Institute at Dindigul. They are posted in the Blocks by the District Health Officer. The Health visitors are also appointed through the same procedure. They undergo a health visitors training course for one year and a half and are posted directly to the Primary Health Centres. All the other staff of the Primary Health Centres are appointed by the District Health Officer in accordance with the prescribed qualification by the health department by calling for the registered candidates from the respective local branches of the Tamilnadu employment exchange.\textsuperscript{34}

Most auxiliary health staff except the health inspectors undergo pre-entry training even during their qualifying period.


The medical officers answer, belong to the Tamil Nadu Medical Services on deputation to the medical services to serve in the Primary Health Centres for a specific period. The medical officers are appointed by the Director of Medical Services on recommendation from the Tamil Nadu Public Service Commission. The Director of Medical Services then forwards a list of these selected medical officers to the Director of Primary Health Centres, who posts them to the various PHCs in the State. On completion of a specific period (which ranges from 2 to 5 years) they return to the medical services to be posted to some hospital in the State. On appointment they undergo 3 weeks' training in rural health and family welfare at the Institute of Public Health, Poonamallee and the Family Planning Institute respectively.

The first consideration in the health manpower administration is that it should be measured against facilities, programmes and objectives rather than merely in relation to population. Secondly in determining the number of each particular category of health worker to be trained, account must also be taken of the relative balance between the different groupings, i.e., between various cadres of health workers and the staffing.

pattern of the primary health care. Thus the three important criteria are - facilities, population coverage and staff pattern.

At the auxiliary level, therefore, a vast area to be covered with either a large or too sparsely distributed population is the major problem. This greatly hampers the effective provision of preventive and promotive services when the efforts seem to cover more on the curative services. Auxiliary personnel having once been trained and sent to rural institutions are seldom given the opportunity of attending any sort of training or upgrading programmes.

The salary structure and other wages for the auxiliary field staff should be capable of being extended significantly to motivate the health personnel to serve in the rural areas. The list below provides the scale of pay of the administrative and auxiliary cadre of the health department. 

1. Director of Public Health : Rs. 2000-125-2500
2. Joint Director : Rs. 1500-75-1750-100-2250.
3. Deputy Director : Rs. 1500-75-1900-100-2000.
4. Assistant Director : Rs. 1150-70-1850.

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criteria are - facilities, population coverage and staff
pattern.

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covered with either a large or too sparsely distributed popula-
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The list below provides the scale of pay of the administrative
and auxiliary cadres of the Health Department. 36

1. Director of Public Health  : Rs.2000-125-2500
2. Joint Director          : Rs.1600-75-1750-100-2250.
3. Deputy Director         : Rs.1500-75-1900-100-2000.
4. Assistant Director      : Rs.1150-70-1850.

36. Government memo.21207/PHC8-2/82-S.3, Directorate of
Primary Health Centre, Government of Tamilnadu, 10th
February 1983.
5. Health Officers : Rs.350-50-1200-60-1500

**Auxiliary Cadres:**

2. Health Inspector : Rs.350-10-420-15-600
3. Auxiliary Nurse Midwife : Rs.295-5-315-10-475
5. Male Nursing Assistant : Rs.250-5-330-10-400

**Ministerial:**

1. Cook-cum-waterman : Rs.250-5-330-10-400
2. Driver : Rs.310-10-470-15-500
3. Sweeper : Rs.250-5-330-10-400

**Health Finance:**

Finance constitutes the most crucial feature of any sphere of activity. In a welfare state, social welfare activities such as health are provided free of cost to all citizens. Therefore, they are areas which possess meagre sources of revenue and depend entirely on the state exchequer for their implementation. Except for a few schemes such as the ESI where the beneficiaries contribute a nominal sum to cover the health and
medical costs, all the health activities and schemes are provided free, on a non-contributory basis.

The State budgetary allocation for public health and preventive medicine including the plan and non-plan expenditure has been an average 1.6% over the last decade. Table I gives the details of health outlay and the total expenditure of the State.37

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Expenditure</th>
<th>Public Health Expenditure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970-71</td>
<td>39384.39</td>
<td>850.08</td>
<td>2.15%</td>
</tr>
<tr>
<td>1971-72</td>
<td>41472.22</td>
<td>800.02</td>
<td>1.92%</td>
</tr>
<tr>
<td>1972-73</td>
<td>49582.32</td>
<td>789.31</td>
<td>1.59%</td>
</tr>
<tr>
<td>1973-74</td>
<td>50012.02</td>
<td>696.92</td>
<td>1.39%</td>
</tr>
<tr>
<td>1974-75</td>
<td>52836.09</td>
<td>691.84</td>
<td>1.30%</td>
</tr>
<tr>
<td>1975-76</td>
<td>57792.01</td>
<td>720.02</td>
<td>1.24%</td>
</tr>
<tr>
<td>1976-77</td>
<td>62863.71</td>
<td>850.32</td>
<td>1.35%</td>
</tr>
<tr>
<td>1977-78</td>
<td>68375.82</td>
<td>972.57</td>
<td>1.41%</td>
</tr>
<tr>
<td>1978-79</td>
<td>78944.82</td>
<td>1190.90</td>
<td>1.50%</td>
</tr>
<tr>
<td>1979-80</td>
<td>98752.36</td>
<td>1286.86</td>
<td>1.30%</td>
</tr>
<tr>
<td>1980-81</td>
<td>110211.13</td>
<td>1500.31</td>
<td>1.65%</td>
</tr>
<tr>
<td>1981-82</td>
<td>121311.02</td>
<td>1893.33</td>
<td>1.56%</td>
</tr>
</tbody>
</table>

Considering the varied and complex nature of the health services, the outlay constitutes a most disproportionate amount. The State's total revenue expenditure is divided into Development and Non-development expenditure. The former constitutes expenditures towards social and community services and economic services. Health is classified under the social services. The allocation for the medical services, family planning, health and water supply is only an average of 15% of the total development expenditure. While the outlay for health amounts to such a low percentage, there is no procedure or machinery to coordinate the health activities and programmes with the other social and economic services through an integrated approach which would to a great extent minimise the financial burden of the health authorities. The Table II below provides the expenditure on revenue account by principal heads.

<table>
<thead>
<tr>
<th>Item</th>
<th>1977-78</th>
<th>1978-79</th>
<th>1979-80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development Expenditure (a+b)</td>
<td>48,604</td>
<td>54,406</td>
<td>57,316</td>
</tr>
<tr>
<td>(a) Social &amp; Community Services</td>
<td>29,975</td>
<td>33,409</td>
<td>36,417</td>
</tr>
<tr>
<td>1. Medical, Family Planning, health, sanitation &amp; water supply</td>
<td>7,105</td>
<td>8,551</td>
<td>9,409</td>
</tr>
<tr>
<td>2. Education, art &amp; culture</td>
<td>16,407</td>
<td>19,094</td>
<td>20,764</td>
</tr>
<tr>
<td>3. Housing, urban development</td>
<td>1,221</td>
<td>1,054</td>
<td>613</td>
</tr>
<tr>
<td>4. Social security &amp; welfare</td>
<td>3,572</td>
<td>3,791</td>
<td>4,008</td>
</tr>
<tr>
<td>5. Other Social &amp; Community services</td>
<td>1,670</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

b) Economic Services

<table>
<thead>
<tr>
<th>Service</th>
<th>1982/83</th>
<th>1989/90</th>
<th>1990/91</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agriculture &amp; Allied Services</td>
<td>9,080</td>
<td>10,238</td>
<td>10,475</td>
</tr>
<tr>
<td>2. Water and Power Development</td>
<td>3,952</td>
<td>3,867</td>
<td>4,169</td>
</tr>
<tr>
<td>3. Transport &amp; Communication</td>
<td>3,194</td>
<td>3,685</td>
<td>3,020</td>
</tr>
<tr>
<td>4. Industry &amp; Minerals</td>
<td>1,543</td>
<td>1,733</td>
<td>1,880</td>
</tr>
<tr>
<td>5. Other Economic Services</td>
<td>1,070</td>
<td>1,474</td>
<td>1,355</td>
</tr>
</tbody>
</table>

The important heads that account for the major revenue are education, agriculture and water supply. All three are allied services which influence and interact with the health system and, therefore, need to be directed towards the achievement of integrated results.

Another important feature of the health finance is the intra-departmental allocation of funds for the various heads of expenditure under health activities. A significant fact in this regard is that an average of 71% of the outlay for public health and preventive medicine is spent on salaries, wages and other allowances such as travelling expenses of the various categories of health workers. The sum earmarked for medicine and diet constitutes only an average of 8.5%. Thus a major portion of the money is spent on the personnel which means that the success
of most of the health schemes depends on the training, skills and the efficiency of the health personnel especially the basic health staff. Further prevention and control of diseases which constitutes the major health policy of the government accounts only for 24% of the expenditure. Table III provides the revenue account (expenditure) for the various heads under public health and Table IV provides the allocation for the various programmes and activities.

The principal financial constraint in the provision of health services is that it is completely a non-profit making endeavour. And the output in terms of cost-benefit analysis is extremely difficult to measure with reference to the investments made in the health sector. Most health programmes yield only long term through highly significant results. It is for these reasons that the budgetary outlay for health has been maintained at a minimum levels. Secondly, and ironically, though health needs constitute an indispensable requirement of any society, they are not felt with commensurate sense of urgency and immediacy when compared with other areas of development such as food, transport, housing and education. But the adverse consequences of its deprivations are no less if not more intense in the health sphere.
<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(rupees in Thousands)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Salaries, wages and other allowances (TA etc.)</td>
<td>66511</td>
<td>71347</td>
<td>81666</td>
<td>92703</td>
<td>101594</td>
<td>122076</td>
</tr>
<tr>
<td></td>
<td>(77%)</td>
<td>(74%)</td>
<td>(72%)</td>
<td>(76%)</td>
<td>(67%)</td>
<td>(64%)</td>
</tr>
<tr>
<td>2. Office expenses, rents, rates and taxes</td>
<td>2515</td>
<td>2090</td>
<td>2453</td>
<td>1955</td>
<td>3524</td>
<td>3945</td>
</tr>
<tr>
<td>3. Materials, supplies machinery and equipment</td>
<td>6142</td>
<td>6418</td>
<td>6604</td>
<td>3155</td>
<td>12253</td>
<td>25396</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Motor vehicles</td>
<td>2367</td>
<td>2550</td>
<td>5052</td>
<td>7629</td>
<td>6748</td>
<td>10892</td>
</tr>
<tr>
<td>5. Medicines &amp; List</td>
<td>4041</td>
<td>9461</td>
<td>9730</td>
<td>11988</td>
<td>16437</td>
<td>15372</td>
</tr>
<tr>
<td></td>
<td>(4.7%)</td>
<td>(9.8%)</td>
<td>(3.6%)</td>
<td>(9.8%)</td>
<td>(10%)</td>
<td>(3.5%)</td>
</tr>
<tr>
<td>6. Other charges</td>
<td>2610</td>
<td>1150</td>
<td>2621</td>
<td>854</td>
<td>4781</td>
<td>3743</td>
</tr>
<tr>
<td>7. Grants-in-Aid</td>
<td>1477</td>
<td>4328</td>
<td>3380</td>
<td>3508</td>
<td>4593</td>
<td>5411</td>
</tr>
<tr>
<td></td>
<td>85633</td>
<td>96344</td>
<td>112576</td>
<td>121803</td>
<td>150030</td>
<td>188335</td>
</tr>
<tr>
<td>Programme</td>
<td>Budget Estimate 1982-83 (Rs. in thousands)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Direction and Administration</td>
<td>9469</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Basic health staff</td>
<td>42415</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. School health</td>
<td>3741</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tribal Sub-Plan</td>
<td>177</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Prevention and Control of Diseases</td>
<td>46161</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Prevention of Food Adulteration</td>
<td>2354</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Prevention of Air and Water Pollution</td>
<td>1774</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Training</td>
<td>10191</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Health statistics</td>
<td>1454</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Health education and Publicity</td>
<td>1678</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Nutrition Programme</td>
<td>12170</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Primary health centres</td>
<td>61072</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Mini-health Centres</td>
<td>2092</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Mobile health teams</td>
<td>15450</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Prevention and Control of visual impairment</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>210201</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
However, if this anomaly is to be rectified by means other than demanding more funds, the health activities should be merged with every other area of social development and all the departments of welfare services, by virtue of their resource position should co-ordinate and integrate their activities with those of the health sector.

But the more pertinent factor is that the distribution of health outlay between public health activities involving the preventive services and the medical functions involving the curative activities should be made on more equitable terms.

The preventive and promotional aspects of public health care sustain and improve the general health of the society and the conditions of the environment. The present emphasis on the disease-oriented, curative services would only provide temporary relief and decrease the self-reliance of the community at large. This would also lead to a more rational allocation for various heads under the public health activities.

In conclusion, it may be stated that the general component of the health administration is sufficiently established in terms of the hierarchical structure at all levels, viz., State, regional and district. However, certain administrative maladies provide Chapter II - Tables II and III.
exist with reference to the organization of the 'line' and 'staff' components, co-ordination amongst the various levels and the personnel pattern at the district and block levels with need to be rectified. At the state level - Directorate of Public Health and Preventive Medicine - though all the administrative units, viz., Deputy Director, Joint Directors and Assistant Directors, form a part of the 'line' grid they serve more as advisory staff functionaries, in the respective areas of specialised activities.

Further all the hierarchical units at the Directorate barring the Director are in-charge of a particular area of specialist activities such as malaria and nutrition. Thus, apart from the Director as the apex there are no units in any level of the hierarchy to co-ordinate the activities concerning various programmes either at the policy level or to consolidate the feedback from the distinct and block levels.

Decentralisation is a principal factor in the administration of primary health care. The creation of 'health regions' under the charge of Regional Assistant Directors was to fulfill this objective at the district level. However, the regional administrative set up lacks well demarcated areas of responsibility based on rational delegation of authority. Despite the regional
reorganisation, the district health officers maintain direct contact with the Directorate on all matters of health, technical and administrative. The health regions provide an apt area for experimental and demonstration projects with reference to epidemiological research, assessment of the auxiliary services required and provided, the appropriate combination of curative and preventive and promotive services in the provision of primary health care in the block area. The regional health structure needs to be strengthened with greater discretionary authority to make necessary alterations and changes in the administrative pattern and the technical processes at the district and block levels, if it is felt necessary, after a detailed examination of the primary health care system.

Another area of health administration that requires reconsideration concerns the creation of an independent Directorate of Primary Health Centres. One of the major objectives of primary health care delivery system is a purposeful admixture of curative and preventive activities, i.e., the medical and public health services, which presently operate under two different directorates with almost complete absence of co-ordination. Thus there is not much rationale in further truncating the existing public health services, through the creation of a new component, especially with such a narrow scope of operations
The Directorate of Primary Health Centres, has not been confined with specific and significant authority or directed towards strengthening the delivery of primary health care in any definite terms. A careful examination of its responsibilities reveals that it is more of a supply and recruiting agency in terms of appointments of medical officers and supply of medicines to the primary health centres. The present situation thus only leads to further diminishing of integration and co-ordination amongst the curative and preventive services and even amongst the various programmes within the preventive area.

The medical officers of the PHC constitute one of the most vital and significant cadres of the primary health services. The present system of deputing them to the public health services from the medical side is not based on any rational or logical analysis. There is no prescribed method or procedure by which medical graduates are deployed in the rural health services or the duration of services at the PHC. This situation only results in long pending vacancies and frequent discontinuity in the provision of health care in the rural areas. Such a mobility of personnel only at the Block level between the curative and preventive services with no permanent terms of reference also affects the preventive and promotive content of the primary health services at the village level. The Medical
Officers feel that they are exclusive representatives of the curative and clinical areas and tend to direct the very course of the primary health delivery system in that direction.

It is, therefore, imperative that the deputation of doctors from the medical services be made in a well defined and a rational way through specific means of selecting medical graduates to serve in the rural areas. It is more important that such a method should be applied uniformly and consistently, instead of the present rule that enjoins in vague terms that all medical graduates should necessarily serve in the rural areas which is followed more in the breach.

A related human resources problem is with regard to the contingent of auxiliary or para-medical personnel at the PHC who perhaps constitute the very core of the primary health services. While all the PHCs should in conformity with minimum requirements of the block consist of a standard complement of auxiliary staff, the specific health needs, disease content, demographic and geographic features of each Block area, however, need to be considered in deploying extra staff and expanding the programmes in that area. Specifically the major components that should influence the size of the auxiliary force are the dispensal of the population in a given area and the out-patient
load at the PHC. Uniformity of the staff content and supply of resources irrespective of these conditions results in disparate conditions and lopsided development in the area of primary health care delivery.

The inadequacy of resources currently being directed towards rural health services mean that even where there is the will on the part of the government to carry out preventive health care activities, the programmes and personnel are not available. It is observed that even when finance is available, it is beyond the capacity of the concerned directorates to conceive and implement necessary health programmes due to the constraints of manpower and materials. Under such circumstances most health programmes, though well conceived, lack sustenance over a period of time and fail to get integrated into a viable primary health infrastructure.

Thus an effective primary health care system requires an administrative pattern that provides adequate technical and managerial back up to the local level health network. The critical difference in the success or failure of the preventive campaigns is whether or not the disease could be eradicated through effective localised action.
Financial allocation for health and distribution amongst the various heads is a vital area that influences the administrative process. The first factor in this area is the need to proportionately balance the financial distribution between the curative and the preventive services and enhance the expenditure on the preventive and promotive areas.