CHAPTER – III
SECTION-I
HOSPITAL MANAGEMENT

3.1 INTRODUCTION

The modern hospital may be viewed as the hub or center of the health care delivery system and as central to the health care of community. In addition to supplying health care to clients, hospitals also provide education to a wide variety of health care workers and to the community. In many cases, they also serve as centers for research and its dissemination. Hospitals are using their status and position in health care to enter into cooperative agreements and alliances with other types of providers, insurance companies, and even other hospitals.¹ Health care plays an important part in our lives; it affects the way we live together and the expectations we have for our standard of living. The delivery of health services to the community is highly visible and open to criticism. Being the most valuable public service in the world helping communities to enjoy long and healthy lives, there is nothing more rewarding than contributing to its success.

Health care services are indeed a personal answer to personal needs; the human factor is of paramount importance as far as consumers of care and providers of care are concerned. To meet patients’ needs, the health system must operate through well-trained and motivated persons. Hospitals play a pivotal role with special emphasis on the education of doctors, nurses, and many other professionals.

The philosophy that hospital and health services should be managed by professionals, qualified in hospital administration needs continuing promotion. The hospital administrations are presented with problems and challenges of increasing complexity and magnitude to ensure running of various departments of the hospital. The ever increasing pressure of patients and their demands for Hi-tech medical care in the hospitals, along with the rising cost of administration of services (with lack of corresponding increase in the health budget), the hospital authorities are faced with
multiplicity of challenges. This dilemma has in fact forced the issue of health care and its cost into the national lime-light. Hospital management must serve as communicator, motivator and protector of administration to treat carefully to achieve the requisite enthusiasm and success to meet the growing needs of the suffering humanity. This will require capacity, capability, tact, experience, patience and resources, besides the requisite support and planning to make the hospital a viable institution.²

Not everyone can be an administrator. It takes a certain blend of skills and a great deal of sensitivity to motivate and lead people to achieve success. Hospital administrators remain vital to the provision of patient care in all respects. How successful the administrator is, depends on his/her own ability, drive and determination: Change is a constant feature of life in health care systems. Advances in medical technology, new thinking on community care and more stringent targets for controlling expenditure means, that the ingenuity and determination of health care managers are continually called into play. As services become more decentralized health care administrators should increase autonomy and assume more responsibility. A good administrator can communicate with professionals, colleagues, patients, public and particular communities- all of whom will depend on a sensitive and rational response to the issues that arise.

In this chapter the researcher wants to explain about Hospital Management and Structure of Health System/ Hospital Management and Nursing in Iran.

Note: The researcher has referred to same function regarding hospital management / administration.

3.2 DEFINITION

The word ‘hospital’ is derived from the Latin word hospitalis which comes from hospes, meaning a host. The English word ‘hospital’ comes from the French word hospitale, as do the words ‘hostel’ and ‘hotel’, all originally derived from Latin.³ The place or establishment where a guest is received was called the
hospitium or hospitale. The term hospital means an establishment for temporary occupation by the sick and injured.

Today hospital means an institution in which sick injured persons are treated. A modern hospital is an institution which possesses adequate accommodation and well-qualified and experienced personnel to provide services of curative, restorative and preventive character of the highest quality possible to all people regardless of race, color, creed or economic status. It conducts educational and training programs for the personnel particularly required for efficacious medical care and hospital service; research assisting the advancement of medical service and hospital services and programs in health education.

World Health Organization (WHO) has defined hospital as an integral part of Social and Medical organization, the function of which is to provide for the population complete health care, both curative and preventive, and whose outpatient services reach out to the family and its home environment; the hospital is also a center for the training of health workers and bio-social research.

Hospital care is multidimensional. It is a service provided by a coordinated group of professional, technical, supportive, and other working under the direction of a physician. The quality of the care received by patients is affected by the adequacy of the hospital facilities, and their maintenance, by the administrative and professional organizations of the hospital, by the competence of the personnel, and by the interpersonal relations among the staff as well as between the staff and the patients.

### 3.3 OBJECTIVES OF HOSPITAL MANAGEMENT

In order to become a well-functioning hospital, management needs to assess their performance. Below is a list of core objectives for managing a hospital.

*Core Management Objectives:*
1- The hospital management works according to goals and objectives of a strategic plan.
2- The community plays a role in the management of the hospital.
3- Efficient and effective management systems are in place.
4- Hospital resources are managed well.
5- The hospital has clear policies and procedures to guide management and service provision.
6- The hospital has processes in place to improve quality.
7- Management encourages teamwork and promotes an enabling environment for staff.

The aim of hospital management is to strengthen the preventive, promotive, curative and rehabilitation aspects of health care to reach the population in the remotest area of the country, state, district and villages and development of health care human resources by proving good quality of medical education.

3.4 FUNCTIONS OF HOSPITAL MANAGEMENT

The hospital, as a social institution, facilitates interaction of a wide spectrum of the society from varied cultural and socio-economic stratum. The hospital is a media through which the scientific technological innovations of medical sciences are put into operation and practiced for the healthful living of the community.

There is a need for efficient management of hospitals and competent administrators; the training of administrators needs to be multidisciplinary. The hospital administrator should evolve sound policies, exercise authority, and ensure the delivery of prompt and efficient health care. He/She should invoke interdisciplinary participation and relate planning to the current situation and future needs. He/she should be responsible for maintaining a good relationship with the community served by the hospital. Public support is essential for efficient working and for generating confidence in the hospital. The most effective administrators are visionaries.
The components of a hospital are: Clinical and Nursing Services, Supportive services and General Business Administration (including maintenance department). If an organization is multidimensional, clinical and nursing services can be separated or general and business administration can be divided into two different units and so on and so forth.

The organization of a hospital exits to help in the functions of the hospital to deliver optimally the services it provides. The organization depends primarily upon the objectives of the hospital. While certain objectives are similar, others can be different. Even when similar, the emphasis may be different. There is a varying mix of objectives. The various variables influencing an organization are: divergent goals, task, technology, structure, people, and power. These variables are interdependent and any change in one of them will cause or effect a change in the others.

To meet the health care challenges, administrators need to integrate and coordinate resources through forecasting, planning, organizing, directing, and controlling. Forecasting is the very core of planning. To forecast is to predict the future. Assessment of various factors, such as social, economic, political, and technological development, has to be made. Planning bridge the gap from where we are, to where we want to go. The task of planning to minimize the risk while taking advantage of opportunities.  

In most hospitals, patient care comes first. In the larger hospitals, there will be some training programs. This is seen maximally in the teaching hospitals, especially, those attached to medical colleges. Some medical research may be carried out in many hospitals. This again is carried out to the greatest extent in the medical college hospitals and in specialized hospitals. More and more hospitals are getting involved in community health and outreach programs.
3.4.1- Patient care

The first and foremost function of a hospital is to give care to the sick and injured and restore the health of diseased persons. Ethically, this care should be given to all without discrimination of social, economic or racial nature. However, the hospitals as national investments in people’s health and as centers for scientific practice of medicine must do many more things than ‘produce’ medical care. The success with which a hospital contributes towards meeting the patient’s need can be measured by the fullness of the life he is able to lead on leaving it. The patient care includes Preventive care (disease prevention), Promotive care (health promotion), Curative care (prolonging life and prevention of disability) and Rehabilitative care (adding life to years).

3.4.2-Training

The hospital is also a centre for the training of health staff and for biosocial research and “an institution that provides inpatient accommodation for medical and nursing care”. The education and training of doctors and nurses have traditionally been carried out in hospitals. It is workshop wherein the student learns by seeing what his superiors and peers do. Radiology, Laboratory, Radiotherapy, highly advanced surgical techniques demand a variety of skills and knowledge, all of which cannot be mastered by the doctor specialist. These activities have created the need for a large number of skilled technicians who are today the vital support to the specialist whether he is the surgeon, physician, diagnostician or therapeutist. These people are indispensable for the all-round excellence of all specialist work. To develop these technical skills, a programme should be organized by the hospital under the direction of people who have the required experience, knowledge and aptitude to teach others. The purpose of in-service education and training programme is to develop such knowledge and skills in all categories of paramedical personnel as are required to make them fit for the job they hold and keep them attuned to the growing needs of their jobs.
3.4.3-Medical Research

The third important function of hospital is to give support to medical research. A good hospital, where the quality of professional work is excellent, is an ideal ground for medical research. As a matter of fact, excellent professional care of patients largely results from the fruits of research into new problems. An attitude of enquiry and investigation should permeate through the day-to-day care of patients. The hospital can develop facilities for research with comparative ease and speed if the staff and administration are properly motivated. True, elaborate research is expensive. There, nevertheless, remain clinical investigations of applied nature that call for little capital investment.

Responsibility for creation of new knowledge is that of any enlightened profession. It is in a hospital that opportunities exist, if not abound, for organized as well as individual initiative for research.

3.4.4-Health Education

The fourth object is to support and assist all activities carried out by various public health and voluntary agencies to prevent disease and promote positive health attitudes in the community though health education.

Hospitals are being reoriented from just being the centers for medical care and treatment to hospitals which are supposed to provide comprehensive system of preventive and curative medicine and rehabilitation services. It has been stated in a WHO document that the hospital is an integral part of a social and medical organization, the function of which is to provide for the population, complete health care, both curative and preventive, and whose outpatient services reach out to the family in its home environment. The hospital has a noble purpose expressed in the phrase “Promotion of health and welfare of the people”.12
3.4.5 - Hospital as an Organization

The hospital is an organization that is made up of different operating units engaged in a variety of activities. The human resources of this organization are individuals with different educational and cultural backgrounds, as well as different experiences in educational and medical treatment fields, who are gathered to utilize technological and professional tools to provide the necessary services for the patients, doctors, nurses, and students.¹³

Every activity of the hospital/health system falls into one of three major organizational areas: fiscal/administrative, professional, and support. Each is important. Small hospitals rely on the administrator to coordinate most of the activities, but in larger hospitals or systems these areas may be the responsibility of assistant or associate administrators.

The fiscal/administrative service area includes the admitting office, medical records, business office, accounting, information management, purchasing, human resources and public relations. Functions within the business office include those of the cashier, credit and collections. Accounting is responsible for budgets, general accounting, payroll, accounts receivable and accounts payable.

In the professional service category is the nursing department, which includes registered nurses, licensed practical nurses, nurse’s aides, surgical technicians, ward clerks, ward aides and orderlies. Headed by the director or nursing services, this department is responsible for all patient-care activities, including operating rooms, labor and delivery rooms and emergency rooms.

Other major professional departments offer ancillary services to patients, such as laboratory, pharmacy, radiology, respiratory therapy and physical therapy. In larger hospitals, these areas are often headed by physicians and provide essential diagnostic and therapeutic services. Skilled nursing units, nursing homes, home
health agencies, swing beds, hospices, rehabilitation and emergency medical services are also part of professional services.

The third major area, the support department (sometimes called general or supportive services), provides services to the other two areas and to patients in the hospital. Dietary or food service, engineering, maintenance, housekeeping, laundry, printing or duplicating department, central supply and the hospital storeroom all fall within this category.\(^\text{14}\)

Therefore, hospital is a highly complex social, economic and scientific organization whose main function is to provide comprehensive health care to the society and to act as a referral centre. Complexity of function in hospitals is increasing due to growth of various specialties and super-specialties. Every hospital desires to acquire the latest technology so that the treatment of the sick can be accurate and quick. The more complex the organization, the more difficult is its management. To overcome this, every organization has to define its goals/objectives. The goals should be comprehensive and achievable, defining the services a hospital wishes to offer. However, the planning of such services depends upon several factors, such as economic condition, scientific know-how, social condition and political will, etc. The peculiarities of a hospital as an organization are as under:

1. The product of the hospital is ‘service’ which cannot be qualified in any economic terms, and no objective criteria can be laid down to evaluate the standard of service.
2. The service in the hospital is always personalized, professional and directly rendered by the medical, nursing and other specialized personnel according to the needs and requirements to each individual.
3. Hospital service is normally emergent in nature and no two situations are similar, needing the same treatment.
4. The wide spectrum of people involved in the hospital activity ranges from the highly skilled professional to a person who may not have visited a school. The work in a hospital is specialized, heterogeneous and professional in nature.

5. The dual control by way of professional authority and the executive authority in the hospital invariably leads to management conflict which is a peculiar situation every hospital administrator has to face in the day-to-day operation.

6. A hospital has to be highly responsive to health need and service expectations of the community.

7. The work in a hospital tends to be both variable and uneven.

8. There is great concern for clarity and responsibility. The cost of making a mistake in patient care is likely to be very high with serious life and legal consequences.

9. Health facilities have abstract goals, diffuse authority, low interdependence, few measures, and require extensive coordination of efforts, resources and demands.\textsuperscript{15}

3.4.5.1- Role of Chief Executive Officer in the hospital organization

The administrator (or superintendent of a hospital) is appointed by the Governing Board. In some cases the title used is chief executive officer (CEO), president, executive vice president or executive director. The administrator is directly responsible to the Board for carrying out the hospital’s formally established polices. The CEO is responsible for the hospital’s operations on a day-to-day basis. The CEO directs the hospital staff and establishes a reporting mechanism for information about the hospital and its services. The information is processed and goes to the Board for review and necessary action. The CEO’s role is as follows:

- Board relationships
- Planning
- Integrating services
• Management
• Evaluating partnering options
• Human resources
• Financial management
• Quality of services
• Regulatory compliance
• Physician and provider relations
• Community health status
• Community relations
• Marketing and fundraising

3.4.6- Hospital as a System

A system may be defined literally as “an organized or complex whole; an assemblage or combination of things or parts forming a complex or unitary whole.” The use of the systems approach requires managers to define the organization in broad terms and attempt to identify the important variables and interrelationships that will affect a decision. It (systems approach) permits managers to concentrate on those aspects of the problem that deserves most attention and allows a more focused attempt at a resolution.

From a management point of view the hospital can be treated as an organized whole and termed as an open system which can be grouped into four distinct sub-systems:

1. Clinical and Nursing Service – Primary Services
2. Supportive Services
3. General Administration and Business Services

Hospital management is complex and multidimensional. It consists of coordinated activities provided by a variety of categories of health personnel,
utilizing a variety of precision equipments and skill and is spread over a large physical area of activity. It is responsible for the synthesis of a ‘whole’ organization consisting of personnel with different skills.

The evaluation of patient care is done indirectly, firstly by examining the quality and adequacy of the factor(s) and facilities which contribute towards better patient care, and secondly by analyzing the medical care process of individual patients from the medical records maintained by a hospital. This product is intangible and dependent on many people individually and collectively and does not lend itself to easily definable standards or to simple units of measurement.\textsuperscript{18}

3.4.7- Inpatient versus Outpatient Care

Two terms frequently used to describe today’s modern hospital services are \textit{inpatient} and \textit{outpatient}. Individuals are termed “inpatient” when they have been admitted for the purpose of staying 24 hours or longer. The outpatient comes to the hospital for services but is expected to stay less than 24 hours. A primary characteristic of hospital care, whether inpatient or outpatient, is its focus on the current problem, rapid assessment, stabilization or treatment, and then discharge to home care or to long-term care.

3.4.7.1- Inpatient Services

Hospitals provide inpatient care in a variety of departments that are commonly designed around the acuteness or seriousness of the patient’s condition. These units compose what most people think of when they use the designation “acute care hospital”. See display 3-1 for an overview of the services provided. Inpatients may be admitted for acute care but many hospitals also provide long-term inpatient services such as rehabilitation, transitional care, and hospice care. Nurses work in all of these service departments, coordinating the nursing care for individual clients, managing the care environment, delegating and supervising care provided by others, and providing direct skilled care.
The person admitted for surgery is an inpatient when he or she is expected to remain in the hospital for at least 24 hours postoperatively. The women admitted in labor become an inpatient because the stay is expected to be at least 24 hours in

<table>
<thead>
<tr>
<th>Types of hospital services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Care</strong></td>
</tr>
<tr>
<td>► Intensive care</td>
</tr>
<tr>
<td>► Coronary care unit</td>
</tr>
<tr>
<td>► Step down units</td>
</tr>
<tr>
<td>► Medical – surgical units</td>
</tr>
<tr>
<td>► Mother – baby units</td>
</tr>
<tr>
<td>► Surgery suites</td>
</tr>
<tr>
<td>► Emergency rooms</td>
</tr>
<tr>
<td><strong>Diagnostic Services</strong></td>
</tr>
<tr>
<td>► Diagnostic imaging</td>
</tr>
<tr>
<td>► Endoscopes centers</td>
</tr>
<tr>
<td>► Laboratory services</td>
</tr>
<tr>
<td><strong>Day surgery centers</strong></td>
</tr>
<tr>
<td>► Pre- and postoperative care</td>
</tr>
<tr>
<td><strong>Medical treatment</strong></td>
</tr>
<tr>
<td>(outpatient)</td>
</tr>
<tr>
<td>► Physical and occupational therapy</td>
</tr>
<tr>
<td>► Respiratory therapy</td>
</tr>
<tr>
<td>► Dialysis</td>
</tr>
<tr>
<td>► Chemotherapy</td>
</tr>
<tr>
<td>► Parenteral nutrition</td>
</tr>
<tr>
<td>► Antibiotic therapy</td>
</tr>
<tr>
<td><strong>Rehabilitation</strong></td>
</tr>
<tr>
<td>(inpatient and outpatient)</td>
</tr>
<tr>
<td>► Nursing care</td>
</tr>
<tr>
<td>► Physical and occupational therapy</td>
</tr>
<tr>
<td>► Vocational and personal counseling</td>
</tr>
<tr>
<td><strong>Transitional care</strong></td>
</tr>
<tr>
<td><strong>Hospice inpatient care</strong></td>
</tr>
<tr>
<td><strong>Hospitality units</strong></td>
</tr>
<tr>
<td><strong>Home care</strong></td>
</tr>
<tr>
<td>► Medical services</td>
</tr>
<tr>
<td>► Hospice home care</td>
</tr>
<tr>
<td>► Infusion therapy</td>
</tr>
<tr>
<td>► Postpartum visits</td>
</tr>
<tr>
<td><strong>Health professional education</strong></td>
</tr>
<tr>
<td>► Schools of nursing</td>
</tr>
<tr>
<td>► Respiratory therapy programs</td>
</tr>
<tr>
<td>► Dietetics</td>
</tr>
<tr>
<td>► Medical residency programs</td>
</tr>
</tbody>
</table>
total and may extend longer if needed. Lengths of stay for acute care are now short, averaging 3 to 5 days for many diagnoses.

Many hospitals have had empty beds because of shortened lengths of stay and the shift to outpatient procedures. In an effort to use costly resources effectively to generate income, hospitals have developed transitional care and rehabilitation units that provide long – term care services. A transitional care or rehabilitation unit allows a hospital to discharge an individual from acute, inpatient care in a timely fashion because the next level of services is guaranteed to be available. Reimbursement is based on long-term care guidelines and the care must meet long-term care standards for skilled nursing care. Even rehabilitation stays are becoming shorter. Inpatient rehabilitation services may be provided for only a brief period of time, followed by outpatient rehabilitation services.

3.4.7.2- Outpatient Services

Many diagnostic and treatment procedures, surgeries and emergency health needs are treated as outpatient care. The outpatient goes through an admission process, has a procedure performed or care delivered, is determined to be ready for home care, and subsequently is discharged.

Sometimes an outpatient is retained for observation beyond the standard 24 hours. Although this individual may be moved to a conventional hospital room, admission as an inpatient may never occur and the person may be discharged as an outpatient with an extended stay. The distinction between the categories of inpatient and outpatient is important in regard to both billing and discharge to a nursing home. Both, Medicare and Medicaid are billed differently for outpatient care than for inpatient care. Medicare payments for nursing home care after hospitalization require that the person be admitted as an inpatient with a minimum 3- day hospital stay. When these conditions are not met, Medicare payment is denied. Older patients and their families may not understand this distinction and how it affects the bills they receive and their eligibility for some types of reimbursement. Nurses must
understand this difference as they help patients to plan for needed care after discharge.

3.4.7.3- Other Services

Hospitals may offer a wide variety of other services that are not directed solely at client care, such as hospitality units and education for health professionals. Day procedures and early discharge for inpatient care may present travel difficulties for individuals who live a long distance from a major care center. To facilitate care for these patients and their families, some hospitals have developed hotel-like services, often termed hospitality units. The patient scheduled for day surgery may plan to arrive the day before and stay overnight at a hospitality unit to be present for the morning surgery appointment. A family member can stay in the unit during the individual’s hospitalization. After discharge, both the patient and the family members may stay one or more days before traveling home. Although the cost of staying in a hospitality unit usually is not covered by insurance, staying at a nearby hotel or motel might not be as convenient. Additionally, if an emergency occurs, the patient in a hospitality unit has care immediately available.

The education of health care providers is an important service of many hospitals. Although the number of hospital-based schools of nursing offering diplomas has been decreasing steadily, some are well supported and expect to continue operation. There are also hospital-based programs of respiratory therapy, dietetics, and other health-related occupations. Many hospitals serve as clinical laboratory sites for individuals enrolled in colleges and universities that provide education for health care professionals.

A physician in a residency program is considered to be in an educational program. Residents receive a salary from the hospital, and are responsible for providing services in return. In addition to augmenting the services of primary physicians, residents often provide medical services for individuals who are part of the medically underserved in community.
As pressure mounts to reduce the number of specialists and increase the number of primary care physicians, there is speculation about what will happen to some medical, residency programs. At this time, part of the funding for these programs comes from Medicare reimbursement policies. These policies allow hospitals to identify educational costs and receive “passed-through” money (i.e., money not related to specific individuals patient care needs) from Medicare to support educational programs. If these funds were withdrawn, diminished, or designated to be used for primary care preparation (such as family practice), many residency programs would not be sustained at the current size. This would also have profound effects on the function of hospitals that rely on resident physicians for day-to-day, 24-hours services. Some hospitals are already moving to augment services by interns and residents with the use of acute care nurse practitioners.19

3.4.8- Nursing Services

“A hospital may be soundly organized, beautifully situated and well equipped, but if the nursing care is not of high quality the hospital will fail in its responsibility.”

- Jean Barrett

Nursing services is one of the most important components of hospital services. Nursing service in a wider context is that part of the total health organization which aims to satisfy the nursing needs of the community, the major objectives of which are to provide:

1- Nursing care required for the prevention of diseases and promotion of health;

2- The nursing care of sick patients – (a) in the interest of his or her mental and physical comfort, and (b) due to the diseases from which he or she is suffering.

Nurses form a very important group – the largest single technical group – of personnel engaged in patient care in hospitals next to doctors, consuming approximately one-third of hospital costs.
The functions of nursing services are as follows.

1- As a basic function, to assist the individual patient in performance of those activities contributing to his/her health or recovery (or to peaceful death) that he/she would otherwise perform unaided had he/she the strength, will or knowledge.

2- As an extension of the above basic function, to help and encourage the patient to carry out the therapeutic plan initiated by the physician.

3- As a member of the health team, to assist other members of the team to plan and carry out the total programme of care.

The organization of nursing care constitutes a subsystem for achieving the hospital’s overall objectives. Nursing care of patients generally takes three forms: (a) technical, (b) educational, and (c) trusting relationship. Whereas educational and trusting relationship has their own importance, it is the technical form which is important to both the nurses and patients. The researcher will explain completely about nursing in next chapter.

3.5 FACTORS THAT INFLUENCE HOSPITAL CARE

A number of factors contribute to the quality of hospital care. The extent to which a hospital tries to achieve better standard with regard to these factors will reflect upon quality of hospital care. The factors are:

3.5.1- The Hospital Staff

Care in hospital involves four types of hospital personnel, viz. The Medical staff, the Nursing staff, the Paramedical Staff and General unskilled Labor. Obviously, an adequate number of each of these categories of personnel should be available on the basis of certain established standards, such as one doctor or one nurse for so many patients, a technician for so many tests, a radiographer for so many X-rays to be taken, a ward orderly for so many beds, and so on. Thereafter, the availability as well as effective utilization of this staff has to be ensured by making rational assignment of duties, authority and responsibility. The points that should be noted are as follows:
(a) Number authorized and available: Is additional human resource in any of these categories required, based on workload?

(b) Qualifications and experience of the staff: Is it adequate?

(c) Availability of specialist or super specialist staff: Are they available when needed or when their services called for? Can honorary staff fulfill the requirement? Proportion of honorary staff to full-time salaried staff.

(d) Absentee rate apart from sudden absence from work due to common cause such as indispositions and planned leave of absence, is there any large scale absenteeism?

(e) Disciplinary cases: undue proportion of cases initiated against staff shows serious lacunae in personnel policies.

(f) Avenues of promotion, pay structure, housing and health benefits and other perks which have a bearing on job satisfaction.

3.5.2- Education and Training

Continued education and in-service training of hospital staff in their respective spheres contribute to better patient care. Regular organized programs should therefore be designed for in-service training of all personnel, in the form of clinical meeting, clinical pathological conferences, seminars, refresher courses, qualification courses for paramedical staff, etc. Suitable incentives there should also be for obtaining higher qualification.22

3.5.3- Physical facilities and Equipment

The location of various departments within the hospital, design of the wards and relationships of nursing stations to the patient beds should be such as to promote smooth flow of patient care activities. Adequate space, good design, functional layout, clean and pleasant environment all contribute to better patient care. Availability of necessary equipment, both technical and common place, in good working condition at the right place also affects patient care.
3.5.4- Clinical and Service facilities
Adequate and appropriate clinical facilities are the most fundamental requirements for good patient care because it will improve quality of medical care. The clinical units should also be complemented adequately by diagnostic and supporting departments, viz. Pathology, X-ray, Pharmacy, Medical Records, Central Sterile Supply (CSSD), Blood Bank, Linen, Diet and so on. These departments should be organized around the clinical services’ routine so that they provide effective service to the clinical areas. Coordination and synchronization of work in these two areas will increase the work output. Any delay in conducting investigations requested for a patient will mean longer stay of patients, delay in making a correct diagnosis, and prolonging the time of commencement of therapy.

3.5.5- Workload
Workload on a particular hospital (or department within a hospital) affects the quality of care and serves as an index for augmentation of resources and inputs, or otherwise. The workload can be assessed from the routine hospital statistics. Comparison of figures of one period with that of the previous period or corresponding period of previous year can give an idea of the trend of workload and utilization of hospital facilities.

3.5.6- Effective use of beds
This is a factor contributing to, as well as a measure of, the quality of care. Effective use of beds means:
(a) Only patients requiring admissions are hospitalized.
(b) A patient should remain in the hospital for minimum number of days so that more number of patients can be treated on one bed in the year. But this will have to be balanced, keeping in view the patients, condition. Too drastic a reduction may increase the frequency of readmissions.
(c) Assessment of the patients admitted in a ward should be carried out frequently both by the senior medical staff and hospital administrator to find out unnecessary admissions and unduly prolonged stay.
(d) The outpatient services should be efficiently conducted to minimize demand on inpatient beds.\textsuperscript{23}

3.5.7- Hospital Administration

The term “hospital administration” covers a large number of activities, as diverse as are the systems of hospital organization themselves. As occasion arises, the hospital administration fulfils very different functions, which may be roughly classified into three categories:

1- Preparation of hospital legislation, planning of the hospital system as a whole, determination of investment policy and of regulations for the operation of hospitals, and establishment of architectural control and standards. These activities come within the State’s legislative and executive power and are essentially the responsibility of the ministry of public health, in co-ordination with other ministries (interior, finance, construction, education, labor and social security, and planning). Some of these responsibilities can be transferred to local or original governmental authorities.

2- Application of hospital legislation and of social assistance provisions by the authorities responsible for the management of hospital services, whether they be local or original, public or private. Administrative boards, where they exist, are responsible for managing the establishments and examining the proposals of hospital directors. Otherwise, the hospital directors are themselves responsible to the appropriate authorities.

3- Daily running of the hospital by the administrative staff concerned with personnel, finance, accounts, and technical services. The director of the hospital and his assistants are in charge of these activities.

This distribution of responsibility naturally varies according to the degree of development and complexity of the hospital administration in each country.\textsuperscript{24}
Management has become a science and management of a hospital both a science and an art. Hospital administration is more than institutional management; it is general administration, business administration, health and medical administrations all combined together. Proper administration of a hospital by a trained and experienced hospital administrator would add to the efficiency and effectiveness of a hospital.

Within the above framework, the organization in terms of facilities and human resources, the service provided in terms of quality, quantity and cost, and the extent of utilization of the facilities available from the mainstay of a general evaluation of a hospital. To this must also be added the element of consumer satisfaction. In addition to this general framework, each individual functional area must also be looked into. The points to be covered under each of the above are given below.

3.5.7.1- Organization

*Organizational Structure*

a) Centralized or decentralized  
b) Unity of command  
c) Span and control of key functionaries  
d) Authority and responsibility  
e) Delegation  
f) Co-ordination  
g) Governing and Executive body.

3.5.7.2- Facilities

A. General structure  
   : Location  
   : Architectural design  
   : Internal traffic pattern  
   : Road, parking spaces, movement  
   : Facilities for visitors
B. **Primary facilities**

- Wards/Patients care units
- Outpatient department
- Emergency and casualty
- Operation theatres.

C. **Supportive facilities**

- Radiology
- Laboratory
- Blood Bank
- Pharmacy
- Central Sterile Supply Department (CSSD)
- Laundry
- Dietary
- Medical Records etc.

3.5.7.3- **Human Resources**

**A. Medical staff**

1. Organizational hierarchy
2. Number of medical staff
3. Qualifications and training
4. Promotional avenues
5. Attitudes, ethics, bedside manners, co-operation and motivation
6. Job satisfaction
7. General rules, regulations, bye-laws
8. Committees: Staff, Medical Audit, Utilization. Tissue committee, etc.
9. Staff meetings, clinical-pathological conferences

**B. Nursing and Technical Paramedical staff**

1. Number
2. Qualification and training
3. In-service training, advancement, promotional avenues
4. Attitudes and motivation
5. Job satisfaction
6. Grievance procedures

3.5.7.4- Services Provided

A. Quality
   a) Existence of audit, or utilization review committee and X-ray, tissue and chart review committee.
   b) Unnecessary admissions, investigations, operations.
   c) Delay in admission, investigation, operations, consultation.

B. Quantity
   a) Number of inpatients treated
   b) Number of outpatients treated
   c) Number of operations performed
   d) Number of deliveries conducted
   e) Number of X-rays taken
   f) Number of laboratory investigations done

C. Cost
   a) Cost per bed day
   b) Cost per medication
   c) Investigation cost per inpatient
   d) Investigation cost per outpatient
   e) Total drug cost
   f) Cost per diet
   g) Total cost of running the hospital
   h) Visible scope for economy in costs
3.5.7.5- Utilization

a) Utilization of inpatient facilities:
   - Bed Occupancy Rate (BOR)
   - Average Length of Stay (ALS)
   - Bed Turnover Interval (BTI)
   - Bed Turnover Rate (BTR)
   - Dead Bed Space (DBS)

b) Utilization of outpatient facilities:
   - Number attended
   - Waiting time
   - Service time

c) Utilization of supportive services:
   - Idle time
   - Productive time

Note: The meaning of efficiency and productivity in medical care is not easy to define especially if it is to be expressed in economic terms that are generally accepted.

3.5.7.6- Consumer Satisfaction

- Involvement of the community
- Number of complaints
- Staff attitudes to patients and visitors
- Extent of ‘left against medical advice’ (LAMA) cases
- Popularity of the hospital.

Note: It should be realized that patient satisfaction is only an indirect or proxy indicator of the technical content/quality of medical care.

3.5.7.7- Gross Results, Complications, Hospital Infection Rate

1. Gross Results
These are the end results of hospital care in terms of:
   a) Fully recovered
   b) Partly recovered
   c) Improved
   d) Not improved
   e) Died
   f) Left against medical advice (LAMA)

2. **Complications**

   Complications may arise any time during hospitalization. Usually, the complication rate does not exceed 2-4 per cent.

3. **Hospital Infection Rate**

   In ideal conditions hospital infections should not occur at all. However, they do occur for reasons both within and beyond the control of hospitals. With all the care that the hospital can take, hospital infection rate should not exceed 3 per cent. Apart from attention to procedures pertaining to equipment, housekeeping, supplies and sterile techniques, precautions should be taken to reduce infection brought in by patients, visitors and hospital personnel.\(^{25}\)

3.6 **HOSPITAL MANAGEMENT: CHALLENGES AND STRATEGIES**

   Today, a hospital is a place for the diagnosis and treatment of human ills and restoration of health and well-beings of those temporarily deprived of these. A large number of professionally and technically skilled people apply their knowledge and skill with the help of complicated equipments and appliances to produce quality care for patients. The excellence of the product- the raison d’être for a hospital, therefore, depends on how well the human and material resources are applied to promote patient care.

   The hospital, the major social institution for the delivery of health care in the modern world, offers considerable advantages to both patient and society. From
the standpoint of an individual, the sick or injured person has access to centralized medical knowledge and technology so as to render treatment much more thorough and efficient. From the standpoint of society, hospitalization both protects the family from many of the disruptive effects of caring for the ill in the home and operates as a means of guiding the sick and injured into medically supervised institutions where their problems are less disruptive for society as a whole. The health care industry will be very different in the future. Indeed, a restructuring of the health care industry is already underway. Change has become so rapid, complex, turbulent, and unpredictable that it is sometimes called simply chaos or white water change.26

Strategies for a change in a given situation are all unique and usually involve several approaches, with one or two dominant approaches. Some pure strategies include fellowship, political, economic, academic, military, and engineering. One of the best ways to combat resistance to change is by believing that change is a natural process that occurs continuously in everyone’s life every minute. Philosophical and concrete approaches to combating resistance may also be tried.

No health care system in the world is stable, and all systems would undergo considerable change in the next 20 years. The drivers of change in the industrialized nations are reaching the limits of welfare state, exhausting traditional methods and tools for containing costs and experiencing increased consumer sophistication and demands. Change is being driven in the developing world by the growth of the middle class, greater demands from that middle class, and the globalization of economics. The following factors will influence more changes in health care system.

- Health transition-demographic, epidemiological, emergence of infections diseases
- Latest advances in the technology-diagnostic, therapeutic preventive
- Discovery and innovation in organ transplantation
Robot and computer assisted medical interventions
Molecular biology
Genetic engineering and gene therapy
Information super highway
Total quality management.
Consumerism
Cost – effectiveness
Ethical and legal issues
Research and development
Evidence-based medicine
Managed care-managing demand (capitation user fees), medical management (review of use, disease management, use of guidelines), and care delivery (telemedicine).

3.6.1-The Environment

A typical hospital has two environmental components: one external and the other internal. The external environment can be further subdivided into two: the general, and task environment. The general environment consists of political legal dimension, economic dimension, socio-cultural dimension, technological dimension, the organization’s international dimension; these dimensions might affect its activities and pose a threat or an opportunity to it.

The task environment includes those external groups and forces with which an organization has direct contact and transactions- competitors, suppliers, regulators, patients, health care professionals and agencies, unions, and professional associations.

The primary components of the internal environment consist of the self, the tasks, the process and skills, the formal organizational design, the organizational culture, the individual employees or people system, together with the leadership function and shared vision of the organization. By analyzing the forces in the
general environment and determining the interactive effects these have on the task and internal environments, management can develop appropriate strategies and structures to meet these demands.

3.6.2-Hospital Organization for Change

The hospital organization must cope up with the rapid changes taking place in medical science and technology as also in values and concepts. It is necessary to view change as a natural phenomenon. Most organizations have been designed to resist change and innovation. This is particularly so with respect to hospitals. Organizational development of hospitals should focus on change. It would improve organizational effectiveness in changing technological, economic and social situations. If the hospital is organized for accommodating change, the administrator will be able to bring about planned change. The administrator implants the required change at the appropriate time, adapting to the new situation. Change occurs constantly. Change is learning and learning is change. Administrations are constantly trying to move a system from one point to another to solve a problem. Administrators, therefore, are constantly developing strategies to change people and to solve problems. The four levels of change are knowledge, attitudes, individual behavior, and group behavior. A participative change cycle moves from knowledge to group behavior and a directive cycle moves in the opposite direction. The change process involves unfreezing old patterns of behavior, introducing a change, and refreezing the new modes of behavior. The four hospital organization changes are as follows:

3.6.2.1- Demographic

The main problem faced by hospital services is their increasing costs or the changes needed to make them more efficient. This always seems to come back to the cost of caring for and treating elderly people and the ‘burden’ that such treatment imposes on the hospital services. There is a feeling that the combination of increasing demands from elderly people and increasing severity of their disabilities will require more and more hospital services and that title of this can be
substituted for by services in the patients home. Quite a high proportion of the hospital beds for the acute, specialties are occupied by elderly people.

3.6.2.2- Economic

Health care costs are a concern for every country, e.g., the USA spends about 14 percent of its gross domestic product on health care. This compares with 9 percent in Canada, France and Germany, about 6 percent in Japan and UK, about 5.6 percent in Iran, and less than 2 percent in India. The price of hospitals and other institutional care has been rising very rapidly in all countries.

Health services provide the service itself (consultation, operations), employ staff, thus having an effect on the individual and the society, on the country (fitter people), and on patients (they live longer and feel better). There are many types of ‘managed internal market’ throughout the world, each with different approaches, different external limits, and different methods of funding. Patients are expected to exercise a choice of what services they want through their general practitioner who is expected to act as their advocate in finding the best quality services.

The pressures on health services to develop new approaches have come, in the main, from a combination of the medical profession and industry developing complex equipment or drugs. The pressure to find new solutions is fed, on the one hand, by professionals and their need to do research into new methods, and on the other, by private industry requiring to develop new markets.

Managed health care system attempts to manage the cost and quality of health care. Improving health revolves around improving the length of someone’s life and the quality of life he/she can achieve, if a particular treatment is given.

3.6.2.3-Technological

The full development of new scientific knowledge in medicine depends on:

- the existence of knowledge which can be applied;
• people with the skills to apply the knowledge;
• social and political acceptability of advance;
• financial backing for its development;
• marketing skills for the development; and
• financial spread for widespread manufacture.

The speed of development of scientific ideas and making them into useful products is affected by social, economic, and political conditions. Pressure on hospitals to use new technology has often been driven by industry where developing these technologies may be a spin-off from other work. Several advances in technology have been taken up by the medical profession for the development of home and community-based care. Development in management methods is as useful to health service as any manufacturing company. Telecommunication and computer technology are good examples of this. Many of the new technologies will help with the development of a less institutionalized health service. Technology can provide more interactive ways of curing, caring, and training.

3.6.2.4- Consumer Choice

Understanding the consumer in terms of what influences his purchase decisions is one of the secrets to successful marketing. The more the marketer knows about consumer, the better he/she is able to choose meaningful target segments, formulate a good marketing plan, think of an effective promotional strategy and create appropriate advertisements. One of the most powerful ways of deciding whether the quality of care is reasonable is to ask the patients who have been treated by the service as to how it affected them. This is not simply because of a desire to please, or to boost the reputation of a service and, therefore, the people providing it. Patient satisfaction is important because satisfied patients are more likely to cooperate with the people giving them health care. They are more likely to take advice they have been given.27
3.6.3- Quality Management

The introduction of total quality management (TQM) assumes that in organizations every one will continually strive for improvement by removing the need for error detection, striving to get it right first time, every time; by being better able to define priorities for action by providing agreed care at the lowest cost; by identifying and removing patient dissatisfaction; by increasing consumers satisfaction; by improving processes and outcome; and by increasing productivity. TQM is a management philosophy that requires total commitments from all levels in the hospital. Its main objectives are:

- Strong customer focus
- Scientific approach
- Continuous process improvement
- Total participation at all levels.

Quality health care has emerged as a watchword in the 1990s. Major concerns to improve the quality of care include:

- Concern for the consumer
- Concern for the quality of care
- Concern for the quality of management

The quality of service in a hospital therefore is, a lot more dependent on the quality of their human resource. Quality begins with the values held by the organization providing the care. The people providing the service may spend time concentrating on the particular audit process which can be monitored, giving less time to others, less tangible, and therefore less measurable, and parts of the work.

The development of clinical guidelines is an approach to improving the quality of care. It may concentrate on the positive side of setting out best practice in some detail. It relies on experts to help set up the guidelines. The best guidelines have the advantage of cutting across different specially boundaries, giving advice
on which parts of the service can be given by general practitioners, nurses and which need specialist care.

Some basic measures to show the quality of care given include:

- hospital mortality
- adverse events (e.g. nosocomial infection)
- malpractice suits
- disciplinary action against doctors
- sanctions from peer reviews
- doctors’ performance in treating specific diseases
- number of services available
- external evaluations
- specialization of doctors
- patients’ assessment of their care.

Quality management systems include medical audit, surgical audit, nursing audit, clinical audit, quality circles, TQM, etc.²⁹

3.6.4- Information Technology

The Information superhighway (internet/multimedia) has revolutionized every sphere of life including health care. The combination of information technology and high speed communication is breaking down the traditional barriers to the movement of information and transforming traditional ways of working. Patient information is absolutely vital to all health care professionals. To improve timely access to good quality patient information and share relevant information with all health care professionals involved in the care of the patient, a management and technology strategy has to be developed which will ensure that the hospital moves to an information society in a structured and controlled way. The strategy is not just concerned with management information; it is there to enable improved clinical information, knowledge and decision support, management of services, and confidence in confidentiality.
Communication is the most important skill in management; everything that an administrator does involves relating to others. Since the purpose of managing is to motivate systems to accomplish goals, communication is necessary to give the system the skill to work and to facilitate the system’s will to work as a team in goal accomplishment. Administrators communicate by telling, participating, delegating, listening, and giving and receiving feedback. Communication is thus the most critical task that administrators must master. Constructive conflict resolution is an important aspect of managerial responsibility. An administrator must have knowledge of possible strategies together with the knowledge of the processes of managing and leading people; the best strategy given the unique environment must then be chosen and implemented.

3.6.5- Human Resources Development

Effectiveness of any health care organization is directly proportional to the cumulative efficiency and effectiveness of the staff. All staff, from the top management to housekeeping, however qualified, need to be given orientation, training and development programs to enhance understanding of their jobs, job skills and ability to perform at a high level, make them responsive and level up to the requirements of their jobs. An employee who is not equal to his job and cannot perform satisfactorily can be a source of great trouble to the organization.30

Human Resource Development Policies will have to lay more emphasis on the following:

- Practice orientation and action learning to promote creativity.
- A feeling of ownership through implementation network.
- Core competence building within the organization to be facilitated by job rotation at all levels of multifunctional teams.
- Job enrichment programs.
- Developing capacity norms and standards, and design and redesign care processes in the face of constantly changing environment.
• Potential development and culture building exercises to improve the productivity.
• Autonomy, openness, and value generation.
• Total quality of care provided.
• Good employment practices.
• Staff development programs to raise the performance standards to the highest level.
• Encouraging innovation.
• Proper leadership

3.6.6- Research and Development

Health services research produces knowledge about the performance of medical care systems, and policy analysis applies this knowledge in defining problems and evaluating policy alternatives. The effectiveness concerns the benefits of medical care as measured by improvements in people’s health. Improvements in health not only include the sum of the individual benefits, that is, reduced mortality rates, increased life expectancies, and the decreased prevalence of disease, but also refer to a distribution of disease and health such that overall economic productivity and well-being are maximized. Another objective of the research and development is the drive for efficiency. Where medical care is viewed as an output, the concern is about production efficiency producing services at least cost.

3.7 MANAGING THE HEALTH SERVICES

Health is fundamental to quality of life. All human beings have an equal right to health. Health policy, health promotion and education, health care, and health care services are means to ensure this fundamental human right. As consumers of health care, which is inherently personal by nature, patients have a right of access of health care (at least at basic or emergency levels), right to considerate care, right to informed consent and the right to information concerning the health services available. They have to protect and improve the health of the community, from birth to death, in a preventive way and, if need be, in a curative or
even in a palliative way. A health care system may belong to public and/or private sectors. Policy making should be response to the accurately assessed health needs of the population.

Hospitals are the key element in any health care system. Being centers of specialized medicine and technology, with large multidisciplinary teams, these institutions deliver a whole range of specialized services. Many hospitals also have a role to play in biomedical research, and in teaching and training of health professionals. Hospitals have, moreover, a key role in health promotion, environmental concern, social human resources, and the creation of patient oriented service and management.

Health care systems are defined as comprising all the organizations, institutions and resources that are devoted to producing health actions. A health action is defined as any effect, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health.

The funding of the health care system by the public authorities themselves, private insurance systems, or by the patient must be adequate and socially equitable. The allocation of budget between the different services should be based on their programs, workload and quality and should, moreover, encourage their flexibility, efficiency, and innovative spirit.

Hospitals and primary health care services are equally important links in a modern health system. The primary health care offers a broad spectrum of professional and flexible services, very close to the patient and his family, and this procedure should be stimulated particularly for chronic illnesses, and for elderly people and the handicapped.

Health care services are both highly specialized and very complex. In each department of specialization there must be a manager to coordinate and direct those
services within and between departments. There also needs to be a manager who directs the overall organization and coordinates its efforts with other health care organization. There are also agencies responsible for managing the health care system in a total community and coordinating their efforts and services with surrounding community health care systems. Modern health care management concerns include an emphasis on increased efficiency, the meeting of administrative challenges, and the development of behavioral insights.

Planning of health care services involves identifying adequate criteria for a better distribution of health care, human resources, infrastructure, and medical technology, taking into account demography and epidemiology. Community involvement in the planning of health care will result in more or less freedom of choice and access, coordination between different services, and regionalization and decentralization in decision making.

3.8 PROFESSIONAL MANAGEMENT IN HOSPITALS

Health care is a concern for every country. Hospitals in developing countries absorb more resources than any other kind of recurrent government spending on health. Although the actual percentage varies from country to country, it is common for 50 to 80 percent of public sector health resources, in money and trained personnel, to be used in hospitals. Review of the health sector in many countries suggests that these large recurrent expenditures on hospitals involve a great waste of resources because of the technical and managerial inefficiency with hospitals. In order to control hospital expenditure and improve the efficiency, management, and role of hospitals in the health sector, there is need to introduce professionalization in hospital management.

The problems of developing and operating the administrative systems that will optimize the mobilization of medical care potential to serve the health needs of the public are substantial and this task calls for adopting professional management as a vital key to development. Therefore, there is a necessary need for high quality
management of hospitals and health services. A fully trained (professional) administrator with multidisciplinary training would ensure economic use of resources, standardization of hospital and equipment designs, prevention of overuse of expensive drugs, and collection of the data for evaluation of performance. He/She will pursue the twin aim of effectiveness and efficiency.\textsuperscript{31}

**3.8.1- The Leadership in Health Care**

The primary responsibility of every manager and a leader is to make an optimum utilization of the human resources in his or her department, unit or organization.\textsuperscript{32} Management and leadership in health care involve an individual’s efforts to influence the behavior of others in providing direct, individualized, professional care. The basic premise of management is that managers set goals that represent some level of growth for a particular group in a particular environment. Managers then develop strategies for reaching these goals. Results are evaluated and altered or new directions are set. Managers constantly design strategies for moving group of personnel to more efficient and more qualitative levels of functioning. In conducting these processes, managers plan, organize, motivate, control and evaluate the work of health care personnel in the delivery of professional care.

Management and leadership involve processes that are essential in making any health care role, in any environment, alive. Responsibility and authority granted by an institution, and one’s personal philosophy on the constituents of quality care and effective management must be integrated with knowledge and an ability to apply existing theories of management in health care practices. Wherever there is placement in health care arena, health care managers will be called upon for creative strategies, disciplined and cost-controlled programs, and the abilities to research and analyze systems critically and chart growth- all in response to rapid health care changes. It is, therefore, mandatory that professionals perceive themselves in the roles of managers and leaders and increase their knowledge and
application of theory and research in practice so that quality, comprehensive, and efficient care is provided to patients in any setting.

### 3.8.2- Specialized Skills

The coordination of management of hospital activities has become increasingly a specialized skill from which the profession of hospital administration has emerged. The ideas upon which modern health care management is based will need time for development and dissemination among all the administrative and technical staff of the hospital. The running of the hospital is not simply the responsibility of a limited number of administrative staff but is a complex interplay between medical, paramedical and administrative staff. A most striking example of this need lies in the determination of admission and discharge policies of the hospital. Not only the consideration of standards of care, technical capacity, and utilization of facilities but also the whole chain of pre- and post-hospitalization networks, including outpatient clinics, health centers, smaller hospital units and the community itself, are involved in the formulation of such policies. Therefore, the need to view the hospital in the total context of community health care must surely be self-evident. It carries with it the need to train staff who can carry this view into practical reality.

### 3.8.3- Professional Training

The concept of professionalization in hospital administration has gone through a vast change lately and hospitals all over the globe have also been influenced by the need for adopting professional management as a key to development. We live in an age of perfection at all levels. Hence, professional training is the basic requirement for the personnel to function effectively in a hospital. Therefore, professional training is required to be imparted by the institutions specialized in professional training. Such professionals should be committed towards professionalization: people who are professionals not merely by virtue of education and teaching but also by attitude, practice and precepts. It is
furthermore necessary that these professionally trained people are recognized as professionals by academic institutions.

3.8.4- Medical Care Facilities

The workload in a hospital doubles every 8-10 years, be it the number of admissions, outpatient attendance, emergency, surgeries, or investigations. There has been a marginal increase in the number of bed vis-à-vis population explosion. This has resulted in an ever-increasing load of patients in hospitals. The overcrowding and poor patient care services have become a common feature, thereby defeating the aim for which health care institutions are meant.

Since it is difficult for any government to provide institutional health care to all its individuals because of the financial constraints, the existing hospital resources need to be used and managed efficiently. Hospital administration needs to be radically strengthened to respond to the issues pertaining to hospital management, patient satisfaction and improving the quality of patient care.

3.8.5- Need for Training

It is necessary for overcoming an existing weaknesses in planning, organization, and management of health systems (especially at District level), by introducing professionalization in Hospital Management. A hospital requires the services of trained management professionals in view of its size as also the large area of activity involved therein. One would suggest that the areas of activities in hospital, viz., General Administration, Medical Administration, Financial Management, Material Management, Manpower Management, and supportive services should be under the control of professionally trained managers.

Other factors that support this decision are:

- principles of management are universal.
- hospitals consume significant quantum of health care budget (resources)
- technological advances and knowledge explosion
- hospital as a complex organization
• growing awareness among the patients
• changing role of hospitals
• hospitals as the cutting edge
• growing trade unionism
• cost containment
• full-time chief executive
• emergence of corporate hospitals.

3.8.6- Medical Requirements

Health care organizations need to be competent in four distinct fields:
• maintenance management for continuity, to keep the organization going at all;
• integrative management for coordination, to pull the organization together for a purpose;
• evaluation management for connection, to compare results with intentions; and
• adaptive management for change, to make the organization different where necessary.

Strong health services management depends on expertise in all four areas of performance because these are the typical medical requirements of health organizations. Management of very high quality is needed for the efficient functioning of health care institutions in the medical field.33

3.8.7- Future Market for Professional Management

Future hospital marketing is basically seeing what the public perceives as its needs, and the hospital identifying those needs and developing the services it is capable of delivering to satisfy those needs.34

Professional management has an immense scope and a bright future market on account of the increasing demand for specialized medical, health care facilities and services. With poor standard of the medical services and facilities provided free
of charge in the existing government and philanthropic hospitals, the hospitals on commercial concepts have been encouraged to provide efficient and quality medical services.

Further, existing hospitals are bound to change their management style for survival under the influence of the speedy advancement in medical technology, growing awareness among patients about their rights, and emergences of monetary consideration of rendering hospital services to the patients in resolving the high operational cost. Therefore, hospital services would no longer be free and of an obliging nature.

By the end of the next decade, hospital organizations will undergo radical changes and the hospitals having professional management will be efficient and productive and will attain stability in the field. Besides the above, hospital management professionals will be remunerated at par with management professionals of other large industrial organizations.

In view of the increase in population, it can be predicted that a large number of hospitals will be set up in the private sector which will generate sizable demand for trained professionals in hospital management. The hospital management body should provide the required financial and infrastructure resources for the development of this specialty. This will encourage the professionals to enjoy job satisfaction and will generate a sense of service to the organization.  

3.9 CLASSIFICATION OF HOSPITALS

Each hospital is distinct in the characteristics as it differs in structure, functions, performance and community it serves. However, hospitals can be classified into different types depending upon different criteria. According to the objectives in general, hospitals can be classified into four categories:
.1. **Teaching-cum-Research Hospitals**
The main objective of these hospitals is teaching based on research and the provision of health care is secondary.

.2. **General or Community Hospitals**
The main objective of these hospitals is to provide medical care to the people while teaching and research is secondary. The most common facility is the general hospital that offers medical, surgical, obstetric, emergency, and diagnostic and laboratory services. The term community hospital is interchangeable in many ways with the term general hospital. Community hospitals provide general hospital services for a specific community.

.3. **Special Hospitals**
*Specialty hospitals* offer only a particular type of care, such as that provided by psychiatric hospitals, women’s hospitals, or children’s hospitals. Specialty hospitals tend to be less common than general hospitals. Many specialty hospitals have become part of larger health care systems in order to have a sufficient referral base and offer their patients wider options.

.4. **Tertiary Care Hospitals**
*Tertiary care hospitals* serve as referral centers for client with complex or unusual health problems. These hospitals have the facilities for specialized care such as level 1 trauma, major burns, bone marrow transplant, and research-based oncology, along with resources for general care. They serve a wide geographic area in addition to their own community. Tertiary care hospitals are usually associated with a university or are part of large medical center.
3.10 TYPES OF HOSPITALS

As a rule, a distinction is made between public hospitals and privately owned hospitals, but there are shades of meaning within the two classifications, and there are terms to describe intermediate types of hospitals.

1- Public hospitals

The public hospital is understood to be an establishment, or a group of establishments, created and managed by public authority. In some cases this authority is local and corresponds to a municipality. In other cases, the public hospital may be created and managed by wider community, such as a department, province, or region, containing a larger or smaller number of communes. In this instance it is administered by the departmental or regional services. Finally, the public hospital may be created and managed by the State itself and be administered directly by a ministry.

The public hospital enjoys legal status; and the administrative board that manages it can buy or sell property, accept donations and legacies bear witness in court, and so forth. In some countries the term “public hospital” covers hospitals that are managed by government services or public municipal, departmental, or national bodies and that are financed as part of the over-all budget for public services.

2- Private hospitals

As rule, the following types of private hospital are distinguished:

(1) Private hospitals run by philanthropic institutions, which make no profit and do not operate on a commercial basis. These are created and managed by very different groups: religious communities or groups lay philanthropic institutions, sickness insurance and mutual aid societies, industrial undertakings, social security organizations, and others.
(2) Private hospitals run on a commercial basis, founded and managed by commercial groups or by individuals as commercial enterprises.

**Public control**

Although the distinctions between public and private institutions are quite clear and definite, and although they are reflected in very different types of administration, public control of both types of establishment tends to be exercised more or less closely at different levels, for three reasons:

1. The conditions of hygiene are subject to control by the public health authorities; and such control, as a rule, includes enforcing certain technical standards and inspection by the public health services.

2. There should be co-ordination between public and private hospitals in order to avoid duplication of equipment and overlapping of services. This may be achieved by deciding the total number of beds required for a given area and making the extension and/or creation of new beds, either public or private, subject to an official authorization.

3. The extension of medical aid to indigent persons and social security facilities for workers means that more and more of the patients admitted to hospitals of all kinds no longer pay the whole cost of diagnosis and treatment and that the budgets of public and private hospitals depend more and more on payments from sickness insurance or other welfare funds. Such financial bodies naturally tend to demand the right to exercise control over the financial and operation of private hospitals, even of those that are run on a commercial basis. This is one of the results of the constantly higher cost of medical and hospital treatment, and leads to budgetary control by the public authorities.\(^{38}\)

**3- Semi-Government Hospitals:** Such type of hospitals act as an autonomous body but the governmental regulations control the functioning of hospitals.

**4- Voluntary Agencies’ and Charitable Hospitals:** The voluntary organizations manage and control the hospitals coming under this category and some of the hospitals are managed by charitable trusts.\(^{39}\)
3.11 FACTORS THAT AFFECT HRM IN HOSPITAL

Hospital organization presents a number of unique human resources management challenges. Managing human resources is the real challenge of hospital managers. To direct all those involved in various activities of parties care, medical training and research programme, to achieve the desired result and to increase the satisfaction level will need more concentrated effort. The various gaps (administrative, technical and communicative) need to be filled up. By democratizing hospital organization, more human resources can participate in decision making so as to bring in a feeling of belonging to the organization and to keep them highly motivated and ready to face the challenge of tomorrow. The following is a list of key factors that influence HRM:

- Management philosophy
- Organizational goals
- Integrating people and technology
- Human resource planning
- Recruitment
- Compensation plans
- Appraisal system
- Education and training
- Channels of self-development
- Motivation
- Employee relations
- Organizational discipline
- Quality of work life

When a hospital decides to enter the long-term-care market, it ventures outside its area of relatively short-term acute care. For this reason, organizational and human resources management problems are likely. As size increases, there is likely to be pressure to add another functional unit to specialize in long-term care. In addition, special organizational units may be needed to deal with domiciliary housing, health promotion programs, out reach efforts such as alcohol and
substance abuse programs, and others of rehabilitation. Recruitment, performance appraisal, training and development, compensation, and employee relations become more complex. New services and new clients require different specialists. The typical hospitals neither have an established network to effectively recruit specialists in the newer fields nor sufficient knowledge of the work to evaluate the performance with confidence. In addition, there is little understanding of the training and development needs of the new professional staff and limited information about compensation customs.  

The organizations consider human resources as the most valuable asset which gains value in time, given the appropriate organizational ethos, environment and support. In a hospital, the openness of the system and its susceptibility to change, prompted by the external environment, is an interesting facet of the complex organization. Health care organizations are dynamic, and ongoing, and hence the performance of the people in hospitals determines their effectiveness.

Human Resource Management contributes to the creation of sound organizational climate characterized by opportunities for growth, fair distribution of work, reward and harmonious relationship. Quality care begins with HRM.

The socialistic pattern of society, the advent of intervention by the state, and of course, the idea of a welfare state must make the managers recognize the importance of human relations and his actions must result in social justice. Workers today are progressive in their outlook besides being well-organized through their trade unions. HRM thus becomes a challenging profession than ever before.

3.12 INDICES FOR MEASURING THE EFFICIENCY OF A HOSPITAL
It is very difficult to measure the efficiency of hospital because of the complex nature of problems that it entails. There are many indices which can help us in evaluation of its quantitative performance. But, what about quality? It can be ascertained only through specially designed surveys. These surveys may be
conducted both by persons inside and outside the organization to locate the 
problems and suggest remedies for its future performance. Research institutions and 
the universities should take interest and help the hospital management to improve 
their services. The researcher mentions below some of the indices which are 
commonly used to measure the efficiency of hospitals.

1. Bed occupancy ratio = \( \frac{\text{Number of patients - days during the year} \times 100}{\text{Number of bed – days during the year}} \)

   This ratio tells us to how far the available bed capacity has been utilized.

2. Average duration of illness = \( \frac{\text{The number of inpatient days during the year}}{\text{Total number of inpatient admissions during the year}} \)

   The index is complementary to the other index ‘average turnover interval’.
   This is more useful if compound for individual diseases.

3. Turnover interval = \( \frac{\text{The total vacant bed-days during the year}}{\text{The number of inpatient admissions during the year}} \)

   The index indicates the number of days on an average per patient for which 
a bed has been remained unused.

4. The average outpatient = \( \frac{\text{The total number of outpatients during the year}}{\text{The total number of outpatients admissions during the year}} \)

5. Average daily outpatient admissions \(^{42} \) = \( \frac{\text{The total number of new out-patient admissions during the year}}{\text{Total number of working days during the year}} \)

   The index tells the average workload on OPD.

6. Cost of daily diet = \( \frac{\text{Total expenditure on diet during the year}}{\text{Total number of inpatient days}} \)
7. Average cost of medicine = \frac{Total\ cost\ of\ medicines\ for\ inpatients\ for\ the\ year}{Total\ number\ of\ inpatient\ admissions}

8. Fatality rate = \frac{No.\ of\ inpatient\ deaths\ during\ a\ specified\ period}{No.\ of\ discharge\ during\ the\ same\ period} \times 100

9. Autopsy rate^{43} = \frac{No.\ of\ autopsies\ performed}{No.\ of\ inpatient\ deaths} \times 100
SECTION –II

STRUCTURE OF HEALTH SYSTEM MANAGEMENT IN IRAN

3.13 INTRODUCTION

The Islamic Republic (I.R) of Iran, covers an area of approximately, 1,648,000 Km², in South West Asia, the Middle East region, is divided into 28 provinces, 285 districts, 718 cities, 741 Bakhshes and over 66,000 villages. Iran has the second largest population, after Egypt, in the Middle East and North Africa region.

The country has a population of more than sixty eight million people, nearly 60% of whom live in urban areas. Approximately 52% of the population is under 20 years of age, making Iran one of the youngest countries in the world. The country’s health and education indicators are among the best in the region.

Health outcomes in Iran have improved greatly over the past twenty years and now generally exceed regional averages. Key to this success has been the Government of Iran’s strong commitment to and effective delivery of Primary Health Care (PHC). Iran’s “Master Health Plan” adopted in the 1980s for the period of 1983-2000 accorded priority to basic curative and preventive services as opposed to sophisticated hospital based tertiary care, and focused strictly on the population groups at highest risk, particularly in deprived areas. Moreover, as a result of the prioritization and effective delivery of quality primary health care, health outcomes in rural areas are almost equal to those in urban areas, with outcomes in terms of infant and maternal mortality nearly identical between urban and rural areas.

3.14 PRIMARY HEALTH CARE STRUCTURE IN IRAN

The health network in I.R. of Iran is an integrated system. In 1972, Iran collaborated with the World Health Organization (WHO) to streamline health care delivery into four levels: health houses, rural health centers, urban health centers and district centers. After 1979, the Ministry of Health and Medical Education designed the new health system based on the primary health care net work.
The constitution of the I.R. of Iran guarantees all citizens the right to health care. The Government’s focus on primary care has resulted in access to primary care services for almost the entire population and health outcomes that are among the best in the region.49

The PHC network of the Islamic Republic of Iran (Figure 3-1) is an integrated and satisfied health care delivery system. The rural health centre is a village-based facility staffed by a general practitioner, several health technicians, and administrative personnel, and has 1-5 health houses under its supervision. The “health house” is the most peripheral rural facility in the network, covering an average of 1500 people. A male and a female villager, known as “Behvarz” staff each health house. Their principal duty is the provision of PHC services for the covered population.

Every health house covers one of several villages (satellite villages). A village on the route to urban areas is accessible to a larger population, and is usually the site of establishment of the health house. Behvarzes are selected from young and interested indigenous people and are trained on an 18-month course in a Behvarz training center. Behvarzes are multi potential community health workers (CHWs) with the skills to deliver PHC services. At present, there are more than 17000 health houses all over the country covering more than 90% of the rural population.

Urban health centers are functionally similar to rural health centers and each of them has 3-5 “health posts” under its control. These urban health posts are responsible for delivering primary health care to urban populations in a way similar to health houses in rural areas. Each health post covers a population of about 12000 individuals.

The district health center is a managerial level and is responsible for the logistic and administrative affairs of the district health network. The directorate of
the district health network is the coordinator of all activities and health programs at district level.50

**Figure 3-1: Health network of the Islamic Republic of Iran**

In Iran a central department does the selection of staff for hospitals belonging to the medical science universities. The selection procedure takes accounts of the job type, individual’s professional capabilities, scientific and practical experience, and special training, acquired skills, and particulars.

3.15 **HEALTH SYSTEM MANAGEMENT IN IRAN**51

The right of all citizens to health care is embodied in the Constitution of the Islamic Republic of Iran which recognizes the rights of all citizens to health as well as an equitable distribution of health services based on Islamic religious principles. In practice this has resulted in a strong focus on basic public health financed from the public budget and delivered to all Iranians through a public primary health care
delivery system run by the Ministry of Health and Medical Education (MOHME), while secondary and tertiary level curative care is financed (and sometimes directly provided) through the compulsory Social Security Organization (SSO) for formal sector employees and their dependents, the Armed Forces Medical Services Organization for members of military and their dependents and the Medical Service Insurance Organization (MSIO) for government employees, rural households, the self-employed, and “others” (e.g. students). In addition, there is the Imam Khomeini Foundation that provides insurance coverage for poor. Private insurance generally is supplemental to these public programs. The MOHME is responsible for overall management of the public health system, regulates the provision of private health services as well as NGOs. The system is described in detail below in terms of eligibility, benefits, financing, medical care provider payment, and the service delivery system.

1-ELIGIBILITY

- All Iranians are eligible for community-based preventive, public health, and limited curative health services, financed and provided through the country’s PHC network. The network effectively reaches about 90 percent of the population and is particularly extensive in rural areas.
- All formal sector workers and dependents have mandatory coverage for curative services through the SSO.
- Members of the armed forces and their dependents are covered through the Armed Forces Medical Service Organization.
- The rest of the population is eligible to enroll in the MSIO, which has four separate funds covering district groups: government employees, rural households, the self-employed, and “others,” (e.g. students). The MSIO is compulsory for the government employees and voluntary for the other groups. All Individuals except for the self-employed are immediately eligible for all benefits upon enrollment. Two changes in the fund for the self-employed have been implemented recently: (i) a three month waiting
period before the individual is covered for inpatient care; and (ii) all household members need to be covered under the fund.

- The Imam Khomeini Relief Foundation finances health services for the poor.
- In 1997, the Insurance coverage among the various financing agencies was as follows:
  - 23.4 million covered through SSO, mostly in urban areas
  - 29.1 million Covered through MSIO, mostly government employees, farmers, students, etc.
  - 3.1 million covered by other institutions like the Imam Khomeini Foundation for the poor
  - 5.4 million not covered by any form of insurance

2-BENEFITS

- Benefits provided through the PHC network include: immunizations for children and pregnant women; pre-and-post natal care; growth monitoring of children under 5; promotion of nutrition and breast-feeding; control of diarrheal diseases and acute respiratory infections; environmental health-water and sanitation; control of endemic diseases such as malaria; surveillance of communicable diseases; provision of basic curative services; and school health promotion.
- The services of the PHC network are fully paid through budget allocations (i.e. there is no cost-sharing premium, etc.).
- MSIO, SSO, and the Military Insurance System provide a comprehensive set of curative care benefits including hospitalization, diagnostic tests, and pharmaceuticals.
- SSO beneficiaries face no cost-sharing for services provided in SSO facilities (where about one-third of SSO financed care is provided), but face cost-sharing of 10 percent for inpatient care and 20 percent for outpatient care for services provided in non-SSO contracted facilities. For care in private non-contractually related facilities individuals face a
coinsurance amount equal to the difference between the facilities charge and SSO’s normal payment level.

- Under MSIO co-payments are set at 25 percent for outpatient and 10 percent for inpatient care services for all individuals except for the rural households. Rural households face a co-payment of 25 percent for inpatient care.

3-FINANCING

- In 1996, Iran spent an estimated 5.7 percent of its GDP on health, some US$101 per capita in exchange rate- based dollars (US$305 in purchasing power parity- adjusted dollars).
- Health spending accounts for some 10 percent of Government spending and 5.3 percent of household spending.
- The public share is estimated to be 2.4 percent of GDP or some 42 percent of total health spending.
- An estimated 85 percent of public spending on health is for recurrent costs.
- PHC (fully financed through Government budget) accounts for 30-35 percent of government health expenditure.
- SSO contributions are earnings related and account for 30 percent of earnings for a wide range of social security and health benefits.
- The Government budget covers MSIO deficits.
- The monthly premium for MSIO (suggested by the MSIO High Council and approved by the Cabinet) is currently Rials 7,920(1$US) for the following funds: Government employees, rural households and “others”. Self-employed pay Rials 10,000. The actual share of the premium paid by the individual depends on which fund the individual is covered through:
  - Government employees: They pay 30 percent of the premium and the Government the remaining 70 percent.
  - Rural households: The Government pays the total amount of the premium.
“Others” (e.g., students, clergies, etc.): They pay between 20 and 30 percent of the premium. The remaining 70 to 80 percent is paid by the relevant institution the individual is a member of.

Self-employed: They pay the full amount of their premium.

4-PAYMENT OF MEDICAL CARE PROVIDERS

- Government health sector employees are salaried and Government facilities are reimbursed based on budgets and/or fee for service payments from Government, MSIO and SSO.
- Private providers are paid on a fee-for-service basis.
- MSIO, the Imam Khomeini Foundation, and SSO reimburse providers on a fee-for-service basis with no overall budget caps or other cost control mechanisms.
- Fees are established by the High Council compound of a number of Ministers and Managing Directors.

5-DELIVERY SYSTEM

- Iran’s health care delivery system can be defined in terms of three levels; the first two of which are encompassed in the PHC network (Figure 3.1).
- The basic PHC first level includes (i) rural health houses with a catchments population of 1,500 staffed by behvarzes (from line allied health workers); (ii) rural health centers, containing a physician and other health workers (e.g., nurse, midwife, dental technician, environmental health worker) supervising a number of health houses with a population base of 9,000; (iii) urban health posts; and (iv) urban health centers.
- The second level of the system is the district health center, which is responsible for the planning, supervision, and support of the PHC network and district hospitals.
- The third level of the system consists of the provincial and specialty hospitals.
Almost 85 percent of all deliveries take place in health facilities and almost 90 percent of babies are delivered by trained health attendants.

Iran has 15,400 health houses, 25,000 behvarzes, 2,200 rural health centers, 300 health posts and 1,900 urban health centers.

Iran has 738 hospitals and 112,590 hospitals bed (table 3-2), 1.6 per thousand population.\(^{52}\)

76 percent of beds are in state hospitals, 6 percent in SSO, 10 percent in the private sector, and the remainder in charity and NGO hospitals.

There are few data on utilization, but hospital occupancy rates are believed to be below 60 percent in state and SSO hospitals.

By the millennium, hospitals beds are projected to increase by 14,000 including 8,000 private, 4,000 SSO and 2,000 public beds.

Iran has 0.8 physicians, 0.5 midwives and 2.3 nurses per thousand populations.

Training for health professionals is carried out at state universities, where education is free.

Doctors must provide 3-5 years of service to the MOHME after graduation before they can go into private practice.

Most doctors have private practices, in addition to part-time contracts in public hospitals.

Iran is turning out 4,000-5,000 new physicians each year.

95 percent of the country’s local drug needs are met through local production.

Generic names are used for all the drugs manufactured and sold in Iran.
<table>
<thead>
<tr>
<th>No.</th>
<th>Name of Province</th>
<th>Government</th>
<th>Private</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of H*</td>
<td>No. of Beds</td>
<td>No. of H*</td>
<td>No. of Beds</td>
<td>No. of H*</td>
</tr>
<tr>
<td>1</td>
<td>East Azarbijan</td>
<td>29</td>
<td>4867</td>
<td>5</td>
<td>537</td>
</tr>
<tr>
<td>2</td>
<td>West Azarbijan</td>
<td>20</td>
<td>2992</td>
<td>3</td>
<td>325</td>
</tr>
<tr>
<td>3</td>
<td>Ardabil</td>
<td>9</td>
<td>992</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td>Esfahan</td>
<td>40</td>
<td>5442</td>
<td>9</td>
<td>585</td>
</tr>
<tr>
<td>5</td>
<td>Ilam</td>
<td>6</td>
<td>742</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>Boshehr</td>
<td>7</td>
<td>973</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>Tehran</td>
<td>59</td>
<td>15521</td>
<td>47</td>
<td>5881</td>
</tr>
<tr>
<td>8</td>
<td>Charmahale-Va-Bakhtyari</td>
<td>7</td>
<td>1042</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>Khorasan</td>
<td>48</td>
<td>7298</td>
<td>8</td>
<td>776</td>
</tr>
<tr>
<td>10</td>
<td>Khozestan</td>
<td>28</td>
<td>5162</td>
<td>5</td>
<td>456</td>
</tr>
<tr>
<td>11</td>
<td>Zanjan</td>
<td>7</td>
<td>1082</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>Semnan</td>
<td>9</td>
<td>976</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>Sistan-va-Balochestan</td>
<td>14</td>
<td>1825</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>Fars</td>
<td>36</td>
<td>4866</td>
<td>12</td>
<td>841</td>
</tr>
<tr>
<td>15</td>
<td>Qazvin</td>
<td>5</td>
<td>904</td>
<td>2</td>
<td>97</td>
</tr>
<tr>
<td>16</td>
<td>Qom</td>
<td>5</td>
<td>913</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>17</td>
<td>Kordestan</td>
<td>10</td>
<td>1805</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18</td>
<td>Kerman</td>
<td>15</td>
<td>2805</td>
<td>2</td>
<td>150</td>
</tr>
<tr>
<td>19</td>
<td>Kermanshah</td>
<td>19</td>
<td>2262</td>
<td>2</td>
<td>200</td>
</tr>
<tr>
<td>20</td>
<td>Kohkililoyeh-va-BoyerAhmad</td>
<td>5</td>
<td>543</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21</td>
<td>Golestan</td>
<td>11</td>
<td>1188</td>
<td>3</td>
<td>258</td>
</tr>
<tr>
<td>22</td>
<td>Gillan</td>
<td>20</td>
<td>3012</td>
<td>6</td>
<td>507</td>
</tr>
<tr>
<td>23</td>
<td>Lorestan</td>
<td>15</td>
<td>1578</td>
<td>2</td>
<td>110</td>
</tr>
<tr>
<td>24</td>
<td>Mazandaran</td>
<td>25</td>
<td>3583</td>
<td>7</td>
<td>451</td>
</tr>
<tr>
<td>25</td>
<td>Markazi</td>
<td>11</td>
<td>1264</td>
<td>1</td>
<td>250</td>
</tr>
<tr>
<td>26</td>
<td>Hormozgan</td>
<td>10</td>
<td>1169</td>
<td>2</td>
<td>112</td>
</tr>
<tr>
<td>27</td>
<td>Hamadan</td>
<td>13</td>
<td>2051</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>28</td>
<td>Yazd</td>
<td>14</td>
<td>1573</td>
<td>4</td>
<td>404</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>492</td>
<td>78438</td>
<td>124</td>
<td>12204</td>
</tr>
</tbody>
</table>
3.16 HOSPITAL MANAGEMENT/ADMINISTRATION IN IRAN

In Iran the hospital management /administration program is a relatively new one. Prior to the Islamic revolution 234 students graduated from the school of Public Health, Tehran University. Only a few of those graduated actually engaged in the hospital administration program, while the majority chose non-related professions. Fortunately, following the Islamic revolution, the hospital administration program was approved by the Cultural Revolution council. Presently 7 universities of medical science (Iran, Shahid Beheshti, Kerman, Esfahan, Ahvaz and Shiraz) at the bachelor’s level, and University of Iran, Tehran and Azad Isalmi at the master’s and Ph.D. levels are offering hospital administration programs.

The hospital administration program like any other health related program is considered to be a professional field,(programming, human resources administration, leadership, controlling and decision making) so it needs to be officially recognized by the officials of the ministry of health, education as well as the university of medical sciences. The graduate of hospital administration program should be able to engage in the management of hospitals.53

3.17 NURSING IN IRAN

Iran, a country of sixty eight million has a national health service which employs over 70,000 nursing personnel who provide nursing care in general and specialty hospitals. Although the population of nurses is approximately one hundred and twenty thousand, many are unemployed. Among the unemployed are those who choose not to work after marriage. Consequently, Iran like other countries is faced with a nursing shortage. The impact of this nursing shortage lead nurses to work more than their required shift of 192 hours per month; with potentially 150 hours of overtime in some parts of the country. The role of nurses is unclear, for although most of them are employed in hospitals, yet few or none are in the role of Public Health Nursing.54
3.17.1- Historical Perspectives of nursing in Iran

Historically, records of nursing in Iran before 1915 showed that nursing care was carried out by household women or servants. Hospitalized patients were also cared for by untrained personnel. Because of this history, lack of basic education, low cultural status, and some religious limitations for women, nursing as a profession/career neither gained high standard nor recognition. However, 1915 is noted as the turning point for nursing in Iran in Oromiyeh city. During that year the American Presbyterian Missionary Society (APMS) pioneered the training of a few nurses in a small missionary hospital. Subsequently, in 1916 a three year nursing school was established in Tabriz. After 1916 there was a gradual increase of nursing schools across the country leading to growing demand for nurse educators who were already scarce. The World Health Organization was appointed to assist in nursing schools, because there was a lack of qualified nurse educators in Iran. The Iranian faculty shortage was further supplemented with recruits from England and United States of America. A two-year program of study was developed and the entry-level requirement for these schools was a minimum of nine years of general education. This minimum requirement failed to attract a large number of prospective nursing students for nursing being predominantly female and in Iran women were prohibited to engage in any social activities that required close contact with men. Avoiding close contact with men is almost impossible in nursing, for healthcare system is not designed to be all male or female and therefore - posed a threat for nursing schools and the recruitment of prospective nursing students.

Following the Second World War, Iran began gaining momentum for advancing nursing as a profession. The Princes Ashraf School of Nursing was established with the appointment of nursing faculty from England and offered a three-year program where the admission requirement was a high school diploma. Then, in 1943 The Iranian Nursing Association (INA) was formed by a group of Iranian nurses who were educated abroad and returned to the country. Next, in 1952, a nursing division was established in the Ministry of Health and this was the first time nursing was officially recognized by the government and become part of
its structure. The first university program for obtaining a Baccalaureate Science in Nursing (BSN) began in October 1967 at Shiraz University.\textsuperscript{59}

The increasing demand for health care in Iran forced the stakeholders of nursing education to develop new initiatives to meet the demand. As a result, in 1975 The Ministry of Sciences approved the Associate Degree of nursing program (ADN). Thereafter, nursing education in Iran was on the move, there were ADN and BSN programs with a Masters of Science in nursing (MSN) program gradually developing. Although nursing education was growing, the numbers of graduates were still inadequate to meet Iran’s demand for health care. For example, between 1915 and 1979 a total of 8,546 nurses graduated to provide healthcare services for a 30 million population. Because fully qualified nurses remained few in numbers, the alternative was to complement the nursing care in hospitals with auxiliary nursing personnel.

In 1979 when the Islamic revolution took place, major social and cultural, changes occurred. These changes not only impacted the health care system, but nursing services too. Previously, the majority of nurses were female and they cared for both men and women. However, as a result of the Islamic Revolution, the government decided that nursing school admissions constitute 50 percent males, with the belief that men should care for men and that women must be separate from men while they engage in social activities.

Despite all the positive changes, bridging the gap of the nursing shortage continued to be a challenge, for new issues continued to merge and there were no easy solutions or “quick fixes” . Some of the issues that emerged were, increased birth rate causing an increased population, and the start of the imposed war between Iraq and Iran which only proliferated Iran’s nursing shortage. Concurrently, the Iranian government decided to re-structure the Ministry of Health where it was re-named the Ministry of Health and Medical Education. Under this ministry new institutions of medical and nursing education were established and some existing
institutions expanded. As a result, after the Revolution 11,274 nurses were trained in the first decade, with an addition of 22,000 more nurses over the next 7 years. Also, after the war, nurses’ aides and ADN nurses were trained too. While providing education for the different types of nursing personnel narrowed the gap of the nursing shortage dilemma, it created role ambiguity and masked the criteria for “who is qualified to practice nursing”.

To bring clarity to “who is qualified to practice nursing”, the Ministry of Health and nurse leaders collaborated and wrote job descriptions for the different levels of nurses. However, these job descriptions were not fully implemented because of several obstacles such as, vague or too abstract job description, work overload, poor staffing in the hospitals, and lack of continuing education for nurses. Consequently, there were several overlaps among the varying roles for nursing personnel in hospitals.

By this time, admissions to nursing schools soared only to be faced with yet another hurdle to overcome. There were too few faculties and a dwindling number of institutions for clinical placement. As a result, many physicians and inexperienced nurses were assigned to faculty roles in nursing education. The mix of physicians and inexperienced nurses drastically changed the philosophy and educational model for nursing education. Nursing education was primarily following the medical model. So nurses were taught the medical management of diseases and to follow physicians’ orders without questioning; this educational model was not only oppressive, it silenced its participants and diminished their self-confidence. All this only exacerbated the difficulty of teaching professional nurses to be assertive and be in control of their practice by giving “voice” to their concerns.

Nurses had no choice but to work overtime and student nurses became part of the work force in order to compensate for the staffing shortage in hospitals, because the government did not recruit enough nurses during the war between Iraq
and Iran. This shift in nursing trend converted nursing care to tasks and these nursing tasks soon became routine care in hospitals. It quickly became evident that new graduates were inefficient, and the MSN programs expanded with the main goal of preparing nurses for faculty roles. So, nurses were educated for roles according to nursing specialists such as, medical-surgical, psychiatric, community health, pediatric, and management, but even with this expansion roles were still not clearly delineated. Thus, many of the graduates from the MSN programs leaned towards nursing education rather than nursing practice. There seemed to be no end to Iran’s nursing issues, it was time for a new approach.

So, after 30 years of fighting for the state recognition, in 2002 Iranian Nursing Organization (INO) was approved by Iran’s legislature and the INO established itself the same year. Now, the INO has the legal responsibility to represent all nurses in all sectors of nursing. Some of its key objectives are, improving the quality of patient care and developing standards for nursing practice. Even though this newly established organization could play a significant role in the development and empowerment of nurses, much time is needed to establish themselves as a governing body for nurses and they certainly have a tough job to shape the future of nurses and nursing in Iran.⁶¹
References


34. Ibid, G.D. Kunders (1999), P.82.
45- World Bank Group Report about Iran, September 2005
47- Ibid, World Bank Report, 2005
