FORMAL FEATURES OF GOVERNMENT HOSPITALS
FORMAL ORGANISATIONAL FEATURES OF GOVERNMENT HOSPITALS

INTRODUCTION:

According to the Constitution of India, which came into force on 26th January 1950, India is a sovereign, secular, socialist, democratic and republic country with a Parliamentary form of government. The Constitution laid a special emphasis on health, in view of the federal nature of the Constitution. The powers have been divided between Union government and State governments. Articles 39, 41, and 47 of the Directive Principles of State Policy stipulate the basic responsibility of the state towards promotion of health and living standards of its people. India is a vast country with more than a billion population which ranks the second largest in the world, after China. The population of India as on 31st March 2011 stood at 1210.19 million of which 623.7 million (51.54 percent) are males and 586.46 million (48.46 percent) are females. The population of India has increased by more than 181 million during the decade 2001-2011. (GOI census report, 2011). There are 28 States and 7 Union territories; the states are largely independent in matters relating to delivery of health care to the people. Each state has developed its own system of health care delivery. The center’s responsibility is mainly of policy making, planning, guiding, assisting, evaluating and co-coordinating the work of the state health ministries (Amin Tabish, 2001:639).

Public Health Administration in India

A systematic public health administration was introduced under British rule in the country. The British rulers appointed several committees and enacted a number of Acts in order to develop the system. The following are some of the important Acts and committees related to the health administration in India in the pre and post independence era.

- The Quarantine Act (1825) was the first enacted for the purpose of improvement of people suffering from communicable diseases.
• A Public Health Committee was appointed in 1864, for surveying the public health needs of Bengal, Madras and Bombay presidencies.

• The Birth and Death Registration Act (1873) was introduced to have a record of births and deaths.

• The Vaccination Act was passed in 1880 for the immunization from contagious diseases.

• A Plague Commission was appointed in 1886 and in the same year Local Bodies Act was passed for transferring and entrusting the responsibility for the health and sanitation of the people to the local authorities.

• In 1887, the Epidemic Diseases Act was passed for the purpose of providing basic framework for the growth of public health policy and its administration.

• The subject “Public Health and Medical Relief”. was included in the transferred subjects of the state list under Montague Chelmsford’ (1919)

• In 1922, under ‘Montague-Chelmsford’ Reforms Act, the Central Government entrusted the functions of health, sanitation and vital statistics to the provincial governments, because most matters relating to health come under the jurisdiction of the states. Still, the Central Government retained its right to advise and control over the provinces through ‘Indian Medical Service Officers’ who were in charge of medical and health administration of districts, all hospitals and medical institutions of every category.

• The ministries in the states were made totally responsible for health policy and administration with the introduction of provincial autonomy under the Government of India Act, 1935(Shankar Rao, 1992:20).

The 1935 Act revitalized the 1919 Act giving greater autonomy to provinces. All health activities of the nation was classified in three lists Federal, Concurrent and Provincial. According to this division, the responsibilities of Central Government include: (i) International Health and Post Quarantine, (ii) Inter-state Quarantine, (iii) Medical
Research, (iv) Higher Medical Education, (v) Administration of Central Agencies, and (vi) Medical and Health Administration of the areas directly administered by the Centre; and the States were given responsibility for all health and medical activities (GOI Act, 1935).

The Drugs Act was passed in 1940 as a central legislation. Though the above steps were taken during the British rule for the development of health of Indian people, the living conditions of the people and health administration could not be restored on account of outbreak of the II World War and partition of our country. During this period the death rate from epidemics like malaria, small pox, T.B etc., was higher. However, an important event took place in the 1940s with the appointment of the ‘Health Survey and Development Committee’ known as Bhore Committee named after its chairman, Sir Joseph Bhore. The committee submitted its report in 1946 and suggested a set up for health administration in India both at the Centre and in states.

**Recommendations of the Bhore Committee:**

- Medical and public health services should be totally tax supported. Health and medical personnel should be offered more salaries.
- Priority should be given to rural needs by providing PHCs for each area consisting of 10 to 20 thousand population.
- Curative and preventive services should be integrated, giving greater emphasis to preventive services.
- Municipal corporation should be vested with local health responsibility.

The Bhore committee gave importance to the concept of primary health or hospital centre with a comprehensive health care on the basis of the ideology of welfare state and suggested a new pattern of organizational and procedural system of health administration in India. It reviewed the health administrative system, prevailing in the rural areas and suggested a unified health authority for the whole district and advocated the constitution of a ‘District Health Board’ as an elected body. In case of larger municipalities or
corporations, which were able to and develop their own health services, they need not be brought under the control of the district health organizations and district medical officers (Park K, 2002:640).

After independence, based on the recommendation of ‘Bhore Committee Report’ (1946), a statutory ‘Central Council of Health’ was created in 1952, comprising of the health ministers of the states to discuss matters of disputes between Centre and states as a whole, but the council did not succeed in coordinating India’s health policies to the extent desirable. Secondly, in India, curative and preventive health services have been integrated at the top administrative level; but not at the grass-root level. Even, where local health centers were designed to provide integrated health services, they often failed in this task, because their personnel were insufficient and inadequately trained in the methods of preventive medicine. As a result, the burden of curative work was overwhelming (Shankar Rao.M, 1992:27).

The introduction of ‘Health Division’ in the Planning Commission was aimed to implement the suggestions of ‘Bhore Committee Report’. During the first, second and third five year plans, a policy was sought to be implemented to control and eradicate communicable diseases and to provide curative and preventive health service in rural areas through the establishment of a ‘Primary Health Centre’ in each community development block with a trained medical personnel.

While the Bhore Committee Report stressed the need for the health developments in urban health centers in big cities, the Planning Commission felt it impracticable to implement the recommendations, because it created a problem to choose between qualitative service and extension of service. However, in 1955, a committee for ‘Model Public Health Act’ recognized the importance of Bhore Committee suggestions regarding the duty of local authority on the maintenance of public health and sanitation.

In 1958, a special committee was also constituted to find out ways and means to control small-pox in our country. In 1961, the Mudaliar Committee’ emphasized the need for extension of the existing 52,000 health centers in India and integration of health
services for the proper implementation of plans and policies by providing training to basic health workers and other categories of medical personnel. In 1962, the ‘Environmental Hygiene Committee’ also urged the need for taking care of environmental sanitation as a pre-requisite for healthy community.

Similarly, the Mukherjee and the ‘Chada’ Committees were constituted in 1962 and 1963 respectively, also stressed the need for appointment of basic health workers for every 15,000 population in rural areas under the supervision of one basic health inspector for every five basic health workers, so as to take up integrated health services in malaria control, small-pox eradication and to prevent the spread of these diseases to urban areas. In 1969 the Indian Government had constituted a ‘Health Review Committee’ in order to find out the cause for strikes by different categories of health and hospital staff. The World Health Organization and United Nations Children’s Emergency Fund have also been trying through their plans and projects to develop the basic health worker concept in the total development of health services (Park.K,2002:646).

![Organisation Chart](image)

**Figure 3.1**

*Source: Government of India, the Ministry of Health –New Delhi, 2012.*
Organogram of Union Health & Family Welfare

Figure 3.2

Source: Government of India, the Ministry of Health - New Delhi, 2012.
The Union Ministry of Health

The Union ministry of health is often described as “Cinderella” among the ministries. In hierarchy it will come after the ministries of finance, defense, foreign affairs, industry, planning and health and education. It is a high-expenditure oriented ministry. The Minister of Health formulates the policy and is accountable to legislature for all the omissions and commissions of the government hospitals. The actions and inactions of the hospitals are subject to discussion in legislature. The health secretary and his assistants provide expert advice and implement the decisions taken by the minister. The health system in India has 3 main links. They are central, state and local or peripheral (Goel S.L, 1981:343-354).

I. **Central Health Administration**: The official organs of health system at the national level are.

1. Ministry of Health and Family welfare,
2. The Director General of Health Services and

1. **Ministry of Health and Family welfare**: It is headed by a Cabinet minister who is assisted by a minister of state and a deputy minister. It has two departments namely department of health and .department of family welfare. They are headed by a secretary, assisted by joint secretaries, deputy secretaries and a large administrative staff. The functions of these departments are:-

   - International health relations and administration of port quarantine
   - Administration of central institutes like All India Institute of Hygiene and Public Health
   - Promotion of medical research
   - Establishment and maintenance of drug standard
   - Co-ordination with states and with other ministries for promotion of health
2. **Director General of Health Services**: He is the principle adviser to the Union government in both medical and health matters. He is assisted by a large administrative staff. The directorate comprises of three main units:

a) Medical care and hospitals,

b) Public health,

c) General administration

It performs the following functions,

A. Guiding and coordinating all the national health programs in the country

B. It maintains all information on health, statistics

C. It maintains medical library.

3. **The Central Council of Health and Family Welfare**: It was set up by a Presidential order on 9th August 1952 under Article 263, for promoting the activities between Centre and state in the implementation of all programs pertaining to national health. The Union Health Minister is the chairman and the health ministers of the state are the members of this council. It does the following functions:

- To consider and recommend broad outlines regarding matters of nutrition, hygiene, health education and facilities for training,

- To make recommendations to the Union Government regarding distribution of grants for health purposes

- It reviews periodically the work accomplished in different states (GOI Report, 1969:10 and19).

II. **State Health Administration**: The executive machinery of the state government is headed by the Governor. Article 163 of the Constitution provides for council of ministers with the Chief Minister as its head to aide and advice the Governor. Businesses of the government, like general administration, local government,
public works, irrigation, health, education etc., are allotted by the Governor among the ministers. In all states, the health management comprises of two units:

1) The State Ministry of Health,

2) Directorate of Health

Minister of the cabinet rank is the political head of the health department. He is responsible for formulating policies and monitoring the implementation of these policies and programs with the help of a large number of administrative staff (Park. K, 2002:642).

**Functions of the Health Minister:** The Health minister of a state has to perform both political and administrative activities. Some of the political functions are.

1. He brings all the bills pertaining to his department for legislative approval.

2. He should see that the policies approved by the legislature are faithfully implemented.

3. He is the custodian of interest of the people (Amin Tabish, 2001:37).

**Administrative Head:** In order to keep the records of the policies framed by the Political head the State administration has to take the help of office which is known as the “State Secretariat”. The word “secretariat” refers to the complex of departments. Health department is headed by an IAS officer of the commissioner’s rank; he acts as secretary to the government in department of health and family welfare. He is assisted by 3 joint secretaries and a secretary along with the administrative staff. The administrator performs the following duties:

- Assisting the minister in policy making, modifying policies from time to time
- Frame, draft legislative and required rules and regulations
- Budgeting and control of health expenditure
- Maintaining contacts with Central and other State governments regarding health issues.
- Overseeing the smooth and efficient running of administrative machinery.
**Directorate of Health:** Below the state secretariat there are executive departments. These departments are headed by specialists and generalists to supervise, coordinate and control the policy framed by the state government. The executive organ of health department in Andhra Pradesh is headed by Director Health Services. Under him, there are four joint directors such as family welfare, food and drug, employment social insurance and administration.

**III. District Health Administration:** In India, the district is the principal unit of health services administration. There are about 640 districts (including union territories) in India (Census India.gov:2011). The government owns nearly half (49 per cent) of the hospitals and 69 per cent of all beds. Local administrations manage 46 per cent of the hospitals with 26 per cent of beds. The remaining beds are in the private sector.
The Health Administrators in Andhra Pradesh:

Minister in charge of Health and Family welfare

Secretary or Commissioner Department Health & Family welfare

Director of Health Services

Additional/Deputy/ Joint Director of Health Services

Assistant Directors Health Services

Commissioner of Family Welfare

Commissioner of Vaidya Vidhan Parishad (APVVP)

Director of Medical Education

Principal/Dean of Medical Colleges

Divisional set up in the state

District Health Organization

Mandal Health Organization

Block level Health Organization

Figure 3.3

Source: www. health.ap.nic.in, retrieved 09.11.2012.
The Department of Health, Medical and Family Welfare provides health care facilities to the people of Andhra Pradesh. The main functions of the department are:

- Formulate, organize, and execute schemes that provide housing for medical and para medical staff
- Construct primary health centres, sub-centres, hospitals, dispensaries, clinics and other health care centres
- Formulate and undertake schemes for acquisition of medical equipment and implementation of infrastructure facilities
- Develop major and minor operation theatres, emergency medical services, wards with attached nursing cubicles and more
- Improve the functioning of hospitals

Impart medical education to undergraduates and post graduates provide training in paramedical courses, and so on (http://health.ap.nic.in, accessed 09.11.2012).

The Directorate of Health in Andhra Pradesh ensures the prevention of the spread of disease in the State. The Directorate is responsible for implementing corrective health care services throughout the state. The main functions of the Directorate of Health are:

- Equip hospitals and health centers with necessary medical equipments
- Supply and distribute preventive medicines to stop the spread of communicable diseases / epidemics
- Provide rehabilitative services for patients of leprosy / encephalitis
- Provide treatment of a variety of disorders
- Promote health awareness among the citizens of the State by offering health education and running health campaigns,
- Ensure patients, met with accidents receive first aid at primary health care centers and district hospitals

Directorate of Health takes care of primary health care and implements the vertical programmes of area hospitals and community health centers. Of these three directorates, the Director of Health is the core one, in the sense that it employs all the doctors. Neither
the Commissioner of Family Welfare nor the APVVP has its own medical staff. The doctors working in the APVVP institutions are appointed by deputation from the DOH, and the Commissionerate of Family Welfare implements its programmes through the staff of DOH in the districts.

The key health officials in the districts are the District Medical and Health Officer (DM and HO) who is responsible for the vertical programmes (including family welfare) and the Primary Health Care Centers (PHCs); the programme officers (all working under the DM and HO, usually in charge of one vertical programme); and the District Coordinator of Health Services (DCHS, the main APVVP person in the district, coordinating all APVVP services). At the PHC level, it is the medical officer who is in charge.

The Andhra Pradesh Vaidya Vidhana Parishad deals with medium scale hospitals, with bed strengths ranging from 30 to 350. The APVVP is managing the secondary care hospitals in the districts and hospitals at sub-district level. The main functions of the APVVP are to maintain and develop the following:

- Major and minor operation theatres
- Outpatient departments with consultation rooms
- Diagnostic facilities with reception area
- Emergency medical services with theatre facility
- Wards with attached nursing cubicles
- Administration department with stores (http://www.apvvp.ap.nic.in, accessed 05.01.2012)

**Directorate of Medical Education (DME):**

The Directorate of Medical Education originated in composite Madras State under British India. It continued, as such in Andhra State formed on 01. 11. 1953 with 11 districts. The Directorate of Medical Education was originally known as Department of Medical Services. The present DME was created in the year 1987, after many changes that
took place from 1967 to 1987 full-fledged functioning of the directorate started from 29. 9. 1987. The DME is located at Hyderabad. It is headed by the Director, Medical Education who supervises the functioning of principals of medical and nursing colleges, superintendents of general and specialty hospitals and chief accounts officers. He is assisted by Additional director, Joint directors, Assistant directors and Chief Information Officer. DME monitors the medical education of Andhra Pradesh. It is the agency through which the government guides, supervises and controls the medical services and health programmes. The directorate regulates the government hospitals in the State by issuing instructions from time to time.

DME is the administrative authority for smooth functioning of all medical colleges and attached teaching hospitals, nursing schools and colleges. The directorate has 38 hospitals, out of them 14 are very large general hospitals attached to each of the medical colleges. Osmania General Hospital, Hyderabad and Gandhi Hospital, Secunderabad together attend to more than 5000 Out Patients and about 300 emergency patients daily. The commercial value of services rendered by the hospitals of DME to the poor people of Andhra Pradesh would run into thousands of crores. An estimate could be made from the following figures - For in Patient treatment the total No. of Beds available are 13924. An amount of Rs. 15/- per day per bed is provided as diet charges and the total comes to Rs. 7, 17, 93, 675/- per year. The above services rendered are supplemented by a large work force.

**Functions and Services of D.M.E.:**

- To provide specialist medical care to people through hospitals.
- To impart medical education to undergraduates, P. G. and super specialities through medical colleges.
- To provide training in para-medical courses like nursing and sanitary inspectors through medical colleges and teaching hospitals.
• To provide dental courses through dental colleges for undergraduate and postgraduate studies.
• Implementation of Bio-Medical Waste Management Act.

Under Act 6 of 1986 – University of Health Sciences Act 1986, the NTR University of Health Sciences was established at Vijayawada to provide for establishment and incorporation of a teaching and affiliating University in Andhra Pradesh for the purpose of ensuring efficient and systematic education, training and research on the Allopathic and Indian systems of medicine, dentistry, and nursing. Hence, the academic activities earlier under the DME were transferred to NTR University of Health Sciences, Vijayawada, from 1986 onwards. (http:/www.dme.in, accessed 12.12.2010).

As the delivery of medical care depends very much on proper staffing, the government after considering the recommendations of various high level committees such as Bhore Committee, Mudaliar Committee, Working Groups of Planning Commission and Indian Medical Council, prescribed revised yardsticks of staffing pattern of the teaching hospitals, and medical colleges (G. O. Ps. No. 88, M & H, Dated 27. 8. 1977) as per which the cadre strength of medical, nursing and para-medical now exists in the teaching hospitals and medical colleges. The pattern of teaching staff in medical colleges and attached teaching hospitals in the state is modified as per Medical Council of India Regulations in the year 1999.

**Directorate of Medical Education has a work force as follows as on 10-12-2012:**

<table>
<thead>
<tr>
<th>s.no</th>
<th>Name of the Category</th>
<th>Sanctioned</th>
<th>In position</th>
<th>Vacant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assistant Professors</td>
<td>2175</td>
<td>2155</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>Associate Professors</td>
<td>343</td>
<td>156</td>
<td>67</td>
</tr>
<tr>
<td>3</td>
<td>Professors</td>
<td>664</td>
<td>630</td>
<td>34</td>
</tr>
</tbody>
</table>

**Figure 3.4**

**Source:** Government of A.P, DME Statistics Records, 2012
# Bed Strength of Hospitals under DME:

<table>
<thead>
<tr>
<th>S.no</th>
<th>Name of the Hospital</th>
<th>No.of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>King George Hospital, Vizag</td>
<td>1052</td>
</tr>
<tr>
<td>2.</td>
<td>Govt.Hospital for Mental Care, Vizag</td>
<td>300</td>
</tr>
<tr>
<td>3.</td>
<td>Govt.TB &amp; Cd Hospital, Vizag</td>
<td>288</td>
</tr>
<tr>
<td>4.</td>
<td>Govt.Victoria Hospital for women and Children, Vizag</td>
<td>147</td>
</tr>
<tr>
<td>5.</td>
<td>RCD Hospital for Children, Vizag</td>
<td>70</td>
</tr>
<tr>
<td>6.</td>
<td>Regional Eye Hospital, Vizag</td>
<td>75</td>
</tr>
<tr>
<td>7.</td>
<td>Govt.Genl Hospital, Guntur</td>
<td>1177</td>
</tr>
<tr>
<td>8.</td>
<td>Govt.Fever Hospital, Guntur</td>
<td>100</td>
</tr>
<tr>
<td>9.</td>
<td>Govt.Genl Hospital, Kakinada</td>
<td>1085</td>
</tr>
<tr>
<td>10.</td>
<td>SVRR Hospital, Tirupathi</td>
<td>710</td>
</tr>
<tr>
<td>11.</td>
<td>Govt.Maternity Hospital, Tirupathi</td>
<td>142</td>
</tr>
<tr>
<td>12.</td>
<td>Regional Eye Hospital, Kurnool</td>
<td>75</td>
</tr>
<tr>
<td>13.</td>
<td>Govt.Genl Hospital, Kumool</td>
<td>1050</td>
</tr>
<tr>
<td>14.</td>
<td>MGM Hospital, Warangal</td>
<td>625</td>
</tr>
<tr>
<td>15.</td>
<td>Govt.Hospital TB &amp; CD, Hanmakonda</td>
<td>100</td>
</tr>
<tr>
<td>16.</td>
<td>Regional Eye Hospital, Warangal</td>
<td>75</td>
</tr>
<tr>
<td>17.</td>
<td>CKM govt.maternity hospital, matwa</td>
<td>70</td>
</tr>
<tr>
<td>18.</td>
<td>Govt.maternity Hospital, Hanmkond</td>
<td>100</td>
</tr>
<tr>
<td>19.</td>
<td>Osmania General Hospital, Hyderabad</td>
<td>1168</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S.n o</th>
<th>Name of the Hospital</th>
<th>No. of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.</td>
<td>Gandhi Hospital, Secunderabad</td>
<td>1012</td>
</tr>
<tr>
<td>21.</td>
<td>Govt.General&amp; Chest Hospital, HYD</td>
<td>670</td>
</tr>
<tr>
<td>22.</td>
<td>Govt.Mental Health Hospital, Hyderabad</td>
<td>600</td>
</tr>
<tr>
<td>23.</td>
<td>Govt.Maternity Hospital, Nayapul, Hyd</td>
<td>462</td>
</tr>
<tr>
<td>24.</td>
<td>S D Eye Hospital, Hyderabad</td>
<td>500</td>
</tr>
<tr>
<td>25.</td>
<td>Niloufer Children Hospital, Hyderabad</td>
<td>360</td>
</tr>
<tr>
<td>26.</td>
<td>Institute of Tropical Diseases, Hyd</td>
<td>330</td>
</tr>
<tr>
<td>27.</td>
<td>MNJ Cancer Hospital, Hyd</td>
<td>250</td>
</tr>
<tr>
<td>28.</td>
<td>Govt.Maternity Hospital, Sultan bazaar, Hyd</td>
<td>160</td>
</tr>
<tr>
<td>29.</td>
<td>Govt.ENT Hospital, Hyd</td>
<td>125</td>
</tr>
<tr>
<td>30.</td>
<td>Govt.Dental College Hospital, Hyd</td>
<td>14</td>
</tr>
<tr>
<td>31.</td>
<td>Govt.General Hospital, Anantapur</td>
<td>300</td>
</tr>
<tr>
<td>32.</td>
<td>URS Hospital ATT To CKM Govt.Maternity Hospital, Warangal</td>
<td>30</td>
</tr>
<tr>
<td>33.</td>
<td>Govt.General Hospital, Vijayawada</td>
<td>412</td>
</tr>
<tr>
<td>34.</td>
<td>Govt.General Hospital, Mangalagiri</td>
<td>200</td>
</tr>
<tr>
<td>35.</td>
<td>Mangalagiri Hospital, Mangalagiri</td>
<td>20</td>
</tr>
<tr>
<td>36.</td>
<td>Rural Health Centre, Nimmakuru</td>
<td>10</td>
</tr>
<tr>
<td>37.</td>
<td>SVRKM Hospital, Vuyyuru</td>
<td>30</td>
</tr>
<tr>
<td>38.</td>
<td>Y.V.C.Oncology Wing &amp; Research Centre, Chinakakani, Guntur</td>
<td>30</td>
</tr>
</tbody>
</table>

**Figure 3.5**

**Total Beds:** 13924
Internal Organization of Government Teaching Hospitals:

The administrative organization of the government hospital could conveniently be discussed under six heads. They are:

1. The Superintendent
2. The Advisory Committee
3. The Administrative Wing (Technical)
4. The Administrative Wing (Non-technical)
5. The Medical Wing
6. The Nursing Wing

Figure 3.6

Source: Srinivasan A.V., (2008), Managing Modern Hospital, Jay Pee publishers, New Delhi.
The Superintendent: Every teaching hospital is headed by a superintendent, who is appointed by the General Administration Department (GAD) on recommendation of the health department, in which generally seniority and administrative experience will be taken into consideration. The post of the superintendent is an extra-cadre post. The senior most surgeon or physician in the hospital is appointed to the post. As head, the superintendent coordinates the multi faceted activities. They are:

- Gives direction to and by acting as a link between the various departments and ward
- Acts as liaison between the administration, other medical and para-medical departments.
- Acts as the chief spokesman of the hospital, deals with the State Government and all other external agencies.
- The superintendent enforces discipline in case of both administrative and medical staff.
- Appoints the class IV employees of the hospital
- He can whenever necessary, make ad-hoc appointments to ministerial and other technical posts. (satyanarayana, 1986:119-137).

The Advisory Committee (Hospital Development Society): (G.O MS no. 874, 27th, December, 2006) Hospital Development Society HDS is constituted with secretary to the government finance and planning department and director general of health services as its chairman. The society meets periodically and under takes decisions to improve the hospitals in various aspects such as patient care, sanitation, user charges and electrical works. The other members of the committee belong to different shades of public life like local MLA’s and other representatives. The committee members can individually inspect the working of various units of the hospital. HDS funds are to be used primarily for the maintenance of the hospital building (Jos Mooij and SheelaPrasad, 2004:1112)
**The administrative wing (Technical):** The administrative wing includes all those personnel who manage the functions of internal coordination, office management, housekeeping, contacts and contracts with external agencies. The technical side of the administrative wing of the hospital includes the two Residence Medical Officers (R.M.Os). The executive authority below the superintendent vests with the R.M.O-I and R.M.O-II. Besides the R.M.O’s several doctors, physicians and surgeons work round-the-clock in shifts to look after the medical and surgical duties.

**The administrative wing (Non-Technical):** The non-medical functions of the hospital’s administration are performed by the lay secretary and other ministerial staff. The lay secretary and treasurer grade-I is the chief of non-technical administration of the hospital while lay secretary grade-II is exclusively made in-charge of medical stores, kitchen and diet arrangements for the patients. From lay secretary-II to office superintendents and clerks, the whole ministerial hierarchy is under the supervisory control of the lay secretary and the treasurer grade-I.

The management of accounts, documentation and maintenance of files is the responsibility of the non technical administrative staff headed by the two gazetted lay secretaries. It is they who manage the audit and any other administrative enquiry instituted by the government. The lay secretaries are supposed to act as the counsel on administrative matters to the superintendent and see that the latter (being a technical man) runs the hospital within the established rules and procedures of the government.

**The Medical Wing:** The medical wing consists of civil surgeons and assistant civil surgeons with the assistance of house surgeons and many others (functionaries) supporting them in the background roles to serve the patients. The teaching civil surgeons and assistant civil surgeons who are also called clinical professors of the medical college are under the dual administrative control of the principal of the college and the superintendent of the hospital. The government teaching hospital structured on several counts is a
divisional structure where clear division can be seen with the organization and semi-autonomous units are created. The units have been grouped according to accepted medical specialties such as medicine, nephrology, neurology, pathology and radiation and so on.

**The Nursing wing:** In the administrative organization of the hospital, the nursing wing is given equal importance along with the medical wing. This can be seen from the fact that the nursing superintendent is placed directly under the superintendent of the hospital and she is also made a member of the advisory committee.

The nursing wing, headed by the nursing superintendent, mainly performs two-fold functions; namely, rendering of patient care services in the hospital and imparting education to nursing pupils. On patients’ care side, the nursing superintendent is assisted by a gazetted nursing superintendent. On the education side, she is assisted by nursing tutors, head nurse and staff nurses who work in the school of nursing attached to the hospital. The nursing superintendent has administrative control over all the nursing staff, the staff working in the hospital and the school, from sanctioning leave to writing their confidential report.

**Human Resource Aspects:** Every organization functions through its personnel; these are the people who strive for the fulfillment of organizational objectives. An organization aims at proper management of its affairs and attainment of goals only when it manages its employees properly and keeps them motivated and committed. The personnel in a hospital play a very vital role in maintaining it fundamentally, a human rather than a mechanical system and the quality of a hospital’s patient care therefore depends on its personnel management. For maintaining the merit and commitment in the personnel, the organization should adopt sound policies of recruitment, training, service conditions, discipline and retirement.

**Recruitment Process:** For all positions of entry into the medical services like assistant civil surgeons, staff nurses and non-gazetted technical and administrative staff the mode of
recruitment is direct and for all other senior positions, it is indirect. Although all senior positions are filled through indirect recruitment, provision is made for direct recruitment for all such positions if suitable candidates are not found from within the service. Selections are made by the A.P. Public Service Commission (APPSC) and they become part of A.P. medical service cadre. In recent years because of financial constraints the government has been giving temporary appointments to assistant surgeons on contract basis. The assistant surgeons can become members of the State Medical Service only when they are recruited by the APPSC.

The other staff like non-gazetted nursing (head nurses and staff nurses) and technical personnel, non-gazetted administrative staff are recruited by the APPSC. The Superintendent of the hospital recruits class IV employees with the assistance of the medical officer. The superintendent can fill or clear leave vacancies.

**Training:** There is an institute at the national level for conducting training from the administrative angle namely the National Institute of Hospital Administration and Education (NIHAE), New Delhi, financed by the Union Ministry of Health. There are some more training institutions such as (i) The All India Institute of Medical Sciences, New Delhi which offers a post-graduate course in hospital administration for doctors and (ii) The South-East Asia Regional Office of World Health Organization, New Delhi which conducts orientation and training programmes in the hospital administration for trainees coming from South-East Asia including India. (Satyanarayana A.V,1986:135).

**Financial Resources:** The State Government finances the total budget as the hospitals do not have any source of income of their own except the rent for paying-rooms which too has to be credited to the government account. The state government which finances the hospital is not in a position to assess its pressing needs and the hospital authorities who can sense the needs, have the least say and involvement in deciding the state of finances. There are some paying-rooms in the large teaching hospitals. For example, Gandhi and Osmania
general hospitals have 4 types of paying rooms and the respective charges per day are as follows: Cubical-Rs 200/-, Single room-Rs 500/-, AC single-Rs 1000/-, and VIP suit-Rs 1500.

The paying-rooms are not fully occupied. So, the income from this source is hardly sufficient to meet the maintenance charges. (Gandhi Hospital, 2010) Due to lack of adequate resources there was stagnation in size and degeneration in the quality of care at the public hospitals. The growth of private sector also has weakened the position of public hospitals in resource mobilization. However, it is noted that the high proportion of outpatient and inpatient treatment in private sector in the state does not any way indicate the under utilization of public hospitals. In fact it is overcrowded and more than full capacity utilization of public hospitals.

**Reforms in Public Health Sector in Andhra Pradesh:**

The scarcity of funds and declining standards in the government hospitals led to the creation of Andhra Pradesh Vaidya Vidhana Parishad (APVVP), an autonomous commission for the management of secondary level hospitals in 1986. The objective was to grant financial and administrative autonomy to the secondary hospitals. Autonomy to the hospitals was aimed at reducing the financial burden on the government through more efficient use of existing resources and mobilizing additional resources. It is also expected to improve the quality of care and patient satisfaction in public hospitals.

As a part of financial autonomy, the APVVP is empowered to receive funds and donations from general public, financial institutions and collect user charges for diagnostic and treatment services. It can even construct and maintain commercial complexes in the hospital premises and organic lotteries to achieve financial self-efficiency. To provide administrative autonomy, the commission is empowered to make its own rules and regulations in running the secondary hospitals. However, all the new rules and regulations are to be placed before the State Legislative Assembly for its ratification.
One of the objectives of APVVP was to introduce flexible manpower policy based on contract system. Another objective in establishing the APVVP was to introduce user charges. However, the matter was so sensitive politically that the first commissioner of APVVP was sacked within three months by the government for announcing the introduction of user charges which created furore in the Legislative Assembly. As a result, the revenue receipts remained an insignificant part of its expenditure that is financed mostly from block grants by the state government (Narayana K.V, 2004:363-364).

**Vision 2020:** Human capital is considered as one of the most important components of a nation’s wealth. In a populous country like India and in Andhra Pradesh, the challenges lie in ensuring that a human is developed to the fullest by enhancing the ability of the people to lead a healthy and productive life. The main aim of Vision 2020 for AP is to provide responsive basic health care services to the poor and vulnerable groups. Its objective is to provide basic and specialized services accessible to Below Poverty Line (BPL) families through health insurance.

**Main priorities of Vision 2020:**

1. Providing universal access to primary health care.
2. Encouraging private investment in territory health care.
3. Focus on improving health levels in disadvantaged groups and backward regions.
4. A strong prevention focus.
5. Enhancing the performance of public health system.
6. It aims to increase life expectancy at birth from 64 to 69 yrs (GoA.P, 1999:92-93)

**Conclusion:**

Effective delivery of health care involves assessment and projection of health situation, definition of the nature of health problems and selection of priorities, definition of goals and objectives, program planning and implementation of services, monitoring and evolution of services. Understanding and conscious practice of these factors will help in effective planning and management of health care.
Right from the first five year plan the government endeavored to improve the health care system. The 11th five year plan provided an opportunity to reconstruct policies to achieve a new vision based on faster, broad based and inclusive growth. One of the objectives of 11th five year plan is, to achieve good health for people specially the poor and underprivileged. It also aimed at the administration of secondary and tertiary care hospital to be professionalized and trained professionals posted as medical superintendents in hospitals, will be allowed to recruit various staff including junior doctors on ad hoc and contract basis. To strengthen government hospitals, during the last few years the centre and state governments have initiated a wide variety of Public Private Partnership (PPP) arrangement to meet peoples growing health care needs. Recently the Government of India has got approval of planning commission for setting up Public Health Foundation in India under which the world class health institutions are set up in rural areas on PPP model (Parliament Digest, Budget session, 2006).