INTRODUCTION
INTRODUCTION

“Healthy people with good working capacity build a strong nation”

Ministry of women and child development of India

The nation’s prosperity and happiness lies in the health of its citizens. Good health is a fundamental human right, and each country is responsible for the provision of adequate health facilities for its population, since health and development are closely inter-twined and inseparable aspects of the government. Promotion of health is essential for national progress (Goel SL, 2005:10). Health contributes to a better quality of life and World peace. The health of a nation is not only an essential component to the nation’s economic growth but also for internal stability. Assuring a minimal level of health care to the population is a critical constituent of the development process. Hospitals and health centers play a vital role in protection of health of the people. Good health delivery is always associated with better capability and leadership (Syed Ameen Tabish, 1998:3).

Health administration is a key part of governance and an important social welfare activity of the government. The Government of India has a separate ministry for health and family welfare. The ministry of health and family welfare is the nodal agency to look after health services. The central government undertakes the responsibility of policy formation regarding health and it develops new health programmes. It provides financial help and technical assistance to the state governments for the implementation of health policies. (Goel S.L and Kumar.R, 2004:48-49).

Definition of Health

In general, health means the ability to lead a socially and economically productive life. The term health is defined by different organizations in different ways.

According to preamble of the Constitution of World Health Organization(WHO), health is defined as “A state of complete physical, mental and social well-being and not merely an absence of disease or infirmity” (Sakharkar B.M, 2009:4)
Health is not only the basic to lead a happy life to an individual, but also necessary for all productive activities in the society (Anand K.K, 1976:1)

According to Christian Medical Commission “Health is a dynamic state of well-being of the individual and the society of physical, mental, spiritual, economic, political and social well being in harmony with environment and God.” (Methodist church, 1985:12).

Health is the state of well being whether it is of the mind, body, or soul. The determinant of good health is often evaluated by physicians and others in the medical field. (http://en.wikipedia.org/wiki/Health: 18-12-2012).

**Dimensions of Health:**

Health is multidimensional. The WHO definition envisages three specific dimensions. As the knowledge base grows, the number of dimensions increases. Although these dimensions function and interact with one another, each has its own nature and for descriptive purposes it will be treated separately. The important dimensions are:

1. **Physical dimension**: The Physical dimension of health is probably the easiest to understand. The state of physical health indicates the notion of perfect functioning of the body. It conceptualizes health biologically as a state in which every cell and organ is functions at optimum capacity and in perfect harmony with rest of the body.

2. **Mental dimension**: Good mental health is the ability to respond to many varied experiences of life with flexibilities and a sense of purpose. It can be defined as “a state of balance between the individuals and the surrounding world, a state of harmony between self and others and that of the environment”

3. **Social dimension**: Harmony and integration within the individual between each individual, other member of society and between individual and the world in which they live can be considered as social well-being. It also can be defined as quantity
and quality of an individual’s inter-personal ties and extent of involvement with the community.

4. **Spiritual dimension**: It means the part of the individual who reaches out and strives for meaning and purpose in life. It is the intangible something that transcends physiology and psychology.

5. **Emotional dimension**: Emotional dimension and mental dimension are closely related. The research revealed the difference between both. Mental health can be seen as knowing or cognition, while emotional health relates to feelings.

6. **Vocational dimension**: This is a new dimension related to the vocational aspects of life. When work is fully adapted to human goals, capacities and limitations, work often plays a role in promoting both physical and mental health. The importance of this dimension is exposed, when individuals suddenly lose their jobs or face mandatory retirement. (Rajesh Choudary and Kumar, 2005: 5)

**Health Care Services in Different Countries:**

In recent years, governments all over the world have accepted the health of the people as public responsibility but the scope of health services varies widely from country to country and is influenced by general, ever changing national, state and local health problems, needs and attitudes as well as available resources. The countries that see health care as basic right, the state is the main provider and health care is largely subsidized. In countries where health care is seen as commodity, the private sector is the dominant provider and the cost of health care is market driven. China, UK, Cuba, Canada and Serbia have the state as major provider while in countries like USA and Australia private sector is the major provider. (Sheela and Rama Chandraiah, 2007: 1). There is a broad agreement regarding the features of health services they are:

- Comprehensive,
- Accessible,
- Acceptable,
• Provide scope for community participation; and
• Available at a cost the community and country can afford.

According to the World Health Organization (WHO), the United States spent more on health care per capita ($7,146), and more on health care as percentage of its GDP (15.2%), than any other nation. Health care in the United States is provided by many distinct organizations; Health care facilities are largely owned and operated by private sector businesses. Health for public sector employees is primarily provided by the government. 60-65% of healthcare provision and spending comes from programs such as Medicare, Medicaid, TRICARE (The department of Defense health care program known as TRICARE. It provides three levels of health care coverage for medical services, medications, and dental care for military families and retirees and their and survivors), the Children's Health Insurance Program, and the Veterans Health Administration. Most of the population under 65 is insured by their or a family member's employer, some buy health insurance on their own, and the remainder are uninsured. The U.S. Census Bureau reported that 49.9 million residents i.e. - 16.3% of the population were uninsured. The expenditure is financed by a complex mixture of public players (federal, state and local government) as well as private insurance. The US government relies on employers to provide health insurance coverage to their employees and dependents. The Government programs are confined to elderly, disabled and some of the poor. Uninsured individuals receive health care services through public hospitals or private providers who finance the care through charity (DeNavas Walt et al, 2011:60-239).

In United Kingdom (UK) since 1948, the National Health Service (NHS) has grown to become the world’s largest publicly funded health service. The NHS offers free primary care, preventive care, mental health care and hospital services for anyone who is a resident of the United Kingdom. With the exception of charges for some prescription drugs, and optical and dental services. Children, the elderly, pregnant women, people with disabilities or mental conditions are exempted from any co-payments. The NHS is funded
largely by general taxation, and government health expenditures contribute roughly 15.6% of total government expenditure in the UK. Notable features of the NHS are the combination of universal coverage and access, very little cost sharing, and tight cost containment. Providers are incentivized under the UK’s system to promote preventive and curative care. Each country in the UK has a health department that is responsible for its own policy decisions, health budget, purchasing and provision of services are delegated further to regional bodies and local public providers. Roughly 11.5% of residents purchase supplemental private insurance to avoid waiting. It has a higher standard of comfort, or choose his/her specialist (Michael Tanner: 2008).

China’s rapid economic growth over the past 25 years improved the standard of living for millions of Chinese but was not coupled with better health or health care. China proclaimed its “open door policy” in 1978, which called for the country’s transition from a social planning economy to a market-based one. As part of this transition, the burden of health care shifted from largely successful state-owned enterprises, such as “barefoot” doctors and the co-operate medical scheme. Health care reforms in the 1980s encouraged localities to raise their own tax revenues to offset decreased central government financing, instated price controls on a catalogue of essential health services to safeguard basic health care, and permitted local health institutes to generate additional revenue by pricing non-essential health services above cost recovery. With this new incentive structure, physician-induced demand for unnecessary healthcare has become a major problem in China. As the market responded to the inadequacies of the 1980s reforms with an increasing number of private health insurance schemes, the free-market response exacerbated the inequities in China’s health system. Market-based health services left more than 500 million Chinese unable to find affordable medical treatment (Chee Hew:2006).

In Australia, from 1984, federal government’s health insurance scheme ‘Medicare’ was introduced to ensure health care for all Australians regardless of income. Medicare
provides insurance against the cost of private medical services, together with access to free care for patients in public hospitals. (http://health_care_australia accessed, 21-10-2012)

The New Zealand health system provides residents with access to a broad range of health services with substantial government funding. The system gives its beneficiaries the choice of their independent general practitioner, and covers preventive and promotional services, in-patient and out-patient hospital care, primary health care services, prescription drugs, mental health care, dental care for school children and disability support services. Patient out-of-pocket, co-payments for general practitioners, non-hospital prescription drugs, some private hospital or specialist care, and adult dental care account for 16% of total health expenditure (Srinath Reddy.K, planning commission.nic.org, 10-11-2012).

In Netherlands, France and Germany health care is financed by a mixture of social and private insurance. In Italy 52% of medical programmes are financed by social insurance and 48% by public providers. Sweden and Britain have a history of planned development health service. The State has an important role in their finance supply and management. In a few socialist countries like Cuba, state is the sole provider of medical care (Syed Ameen Tabish, 1998:757-760)

However, the provision of health for people in any country is a very important factor, because it has not only an independent value for individuals but also an important factor in a country’s standard of living as well as socio-economic development
The Health Care Systems in India:

According to the Indian Constitution, health is a State subject, providing health services to all people is the responsibility of State Government with assistance of local health organizations. In India, the government regulates and maintains health standards, provides preventive and curative services and build up the infrastructure for medical and health services. The Indian Medical Central Council Act (1970) that came into existence with approval of parliament has the power to grant permission to establish any health institution in the country (Universal’s Bare Act, 2004). The health care system in India is represented by five major sectors which differ from each other by the health technology applied, and source of funds for operation (Park K, 2002:662). These are:

Figure 1.1

Source: Health at a Glance 2011- OECD Indicators. WHO
1) Public health care Sector:
   a) Primary Health Care
      - Primary Health Centers (PHC)
      - Sub centers
   b) Hospitals/Health Centers
      - Community Health Centers (CHC)
      - Rural Hospitals
      - District Hospitals/Health Centers
      - Specialist Hospitals
      - Teaching Hospitals
   c) Health Insurance Schemes
      - Employee State Insurance
      - Central Government Health Scheme
   d) Other Agencies
      - Defiance Services
      - Railways

2) Private Sector:
   a. Corporate Hospitals, polyclinics, nursing homes, and dispensaries
   b. General practitioners and clinics

3) Indigenous System of Medicine:
   - Ayurveda and Siddha
   - Unani Tibbi
   - Homeopathy
   - Unregistered practitioners

4) Voluntary Health agencies

5) National Health programs
**Health policy in India:**

In India a systematic public health administration was introduced under the british rule. The british rulers appointed several committees and enacted a number of Acts in order to develop the health system. After independence the era of scientific planning in India started with the establishment of Planning Commission in 1950. Since then, the Government of India has been giving priority to health matters and several steps have been taken through five year plans. Health policy in India is formulated in each of the five year plan.

**First Five Year plan (1951-56):** Many factors like social, economical and educational have an intimate bearing on the health of a community. The first five year plan gave prior importance for proper housing, water supply, it increased the number of hospitals and dispensaries in the country.

**Second Five Year plan (1956-61):** During the second five year plan, arrangements were made for the training of an increased number of nurses, midwives, pharmacists, sanitary inspectors and other technicians at medical colleges and larger hospitals.

**Third Five Year Plan (1961-66):** The broad objective of the third five year plan was to expand health services and family planning programmes to bring about progressive improvement in the health of people by ensuring a certain minimum physical well-being and creating conditions favorable to greater efficiency and productivity.

**Fourth Five Year Plan (1969-74):** Family planning found the highest priority in this plan. It aimed at bringing about a group acceptance of a small-sized family and personal knowledge about family planning methods. During this plan, efforts were made to prevent communicable diseases like malaria, small pox etc. It established leprosy control units in different parts of the country.
**Fifth Five Year Plan (1974-79):** The primary objective of fifth five year plan was to increase the accessibility of self service to rural areas and quality improvement in education and training of health Personnel.

**Sixth Five Year Plan (1980-85):** During this plan, priority was given to health infra structure. Incomplete buildings and some new buildings were constructed for family planning centers. Primary Health Centers (PHCs) were upgraded as 30-beded hospitals. Medical college admission had also increased.

**Seventh Five Year Plan (1985-90):** In the seventh plan, priority was assigned to medical educational facilities, training of paramedical, to meet the requirements of community health services.

**Eighth Five Year Plan (1992-97):** This plan gave importance to human development and committed to attain “Health for all by 2000”. It initiated major efforts to expand health and educational facilities.

**Ninth Five Year Plan (1997-2002):** The approach during this plan was to enhance the quality of primary health and promotion of human resource for health. To enable Panchayat Raj Institutions (PRIs) to plan, monitor and improve the work environment in industrial and agricultural sectors. (Goyal R C, 2000: 19-37).

**Tenth Five Year Plan (2002-2007):** The aim of this plan was to evolve and implement a whole range of comprehensive norms for service delivery, prescribing minimum requirements of qualified staff, conditions for carrying out specialized interventions and a set of established procedures for quality assurance; promotion of rational use of diagnostics and drugs; evolving, implementing and monitoring transparent norms for quality and cost of care in different health care settings; exploring alternative systems of health care financing including health insurance so that essential, need based and affordable healthcare is available to all; improving content and quality of education for
health professionals and Para medical, so that all health personnel acquire the necessary knowledge, attitude, skills, to effectively take care of the health problems, and improve the health status of the people. The other aims of the plan are development of accurate Health Management Information System (HMIS) utilizing currently available IT tools; this communication link will send data on births, deaths, diseases and request for drugs, diagnostics, equipment and status of ongoing programmers through service channels. It will also facilitate decentralized district based planning, implementation and monitoring; building up an effective system, strengthening and sustaining civil registration, sample registration system; improving the efficiency of the existing healthcare system in the government, private and voluntary sectors, building up appropriate linkages between them; mainstreaming Indigenous System of Medicine (ISM) practitioners, so that in addition to practicing their system of care, they can help in improving the coverage of the National Disease Control Programmes and Family Welfare Programme; increasing the involvement of voluntary and private organizations, self-help groups and social marketing organization in improving access to health care; improving inter sectoral coordination; devolution of responsibilities and funds to Panchayati Raj institutions (Planning Commission of India, 10th five year plan, 2002-2007).

Eleventh Five Year Plan (2007-2012): The objectives of this plan are assessment of procedures for estimating mortality/morbidity in women and children, review of the functioning of family welfare infrastructure and manpower in rural and urban areas and suggesting measures for rationalizing, restructuring the infrastructure, development of an effective health system, a broad overview of the current health status and development of appropriate policy interventions is. Regulations and setting standards for measuring performance of public/private sector in health, issuing guidelines to help the states, development of partnership with non governmental stakeholders, developing framework for effective interventions through capacity development and decentralization including transfer of schemes and financing in the states, where the Central Government would
continue to play a role. Effective monitoring of performance, support for capacity
development at all levels, sharing the best national and international practices, providing
more financial resources to drive reforms and accountability, disease surveillance,
monitoring and evaluation will be the thrust of the Central Government’s interventions.
(GOI Health and Family Welfare: 2007)

**Union Ministry of Health and Family Welfare**

The Union Ministry of Health and Family Welfare is the apex executive
organization dealing with issues of health and family welfare in India. It lays the national
health policy in accordance with the policy decisions of the Cabinet. “Health” is the state
subject in India, so the Union Ministry of Health and Family Welfare acts as a co-ordinator
between the state health departments, Planning Commission, Central Council of Health
etc., besides implementing various national programmes and items under Union list and
Concurrent list. In the process, it is aided by the Directorate General of Health Services.
Health administration at the apex level of the Government of India consists of Secretary for
Health, Secretary for Family Welfare supported by additional and joint secretaries who are
recruited from the Indian Civil Service. The rest of the organization is mostly
program/project based. Ad-hoc project structures such as TB project and Malaria project
etc., Since state governments implement the projects and deliver the regular health services
they have fairly well demarcated systems. Separate directorates or head offices usually
exist at state capital for primary, secondary and tertiary health care which includes medical
colleges and medical education. Many states have separate structure for family welfare
operations, since population control through family planning is given great importance. At
district level, health administration consists of a number of officers and doctors who on an
average handle 10 to 15 hospitals, 30 to 60 primary health centers and 300 to 400 sub
centers. This entire complex arrangement results in a number of vertical channels of
information, multiplicity of agencies, dual reporting systems etc (Pramod K .Singh:2007).
The Health Sector in Andhra Pradesh:

Andhra Pradesh is the fifth largest state in India and it is fifth most populous state with a population of 8.64 crores. The state largely dependent on agriculture for revenue. The Department of Health, Medical and Family Welfare in Andhra Pradesh consists of four most important governing bodies. They are:

1. The Directorate of Health (DOH),
2. Directorate of Health and Family Welfare,
3. Andhra Pradesh Vaidya Vidhana Parishad (APVVP),
4. Directorate of Medical Education.

The Directorate of Health (DOH) takes care of primary health care and implements the vertical programs. The Commissioner of Family Welfare is responsible for family planning, pre and post natal care and immunizations. The APVVP manages the secondary care hospitals in districts and hospitals at sub-district level (area hospitals and community health centers). The APVVP is an additional structure in the state level health administration and is specific in Andhra Pradesh. Conceived and implemented in the mid 1980s to give more attention to secondary level health care, the setting up of the APVVP has helped to streamline and improve infrastructure and services in secondary hospitals. The Directorate of Medical Education is the administrative authority for the smooth functioning of all medical colleges and attached teaching hospitals, nursing schools and nursing colleges. Of these four bodies, the Director of Health is the core one, and the Commissionerate of Family Welfare implements its programs through the staff of the DOH in the districts.

The important health officials in the districts are the District Medical and Health Officer (DM&HO), who is responsible for the vertical programs (including family welfare) and the Primary Health Care Centers (PHCs); the program officers (all working under the DM&HO, and usually in charge of one vertical program); and the district Coordinator 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 (Jos Mooij and Sheela Prasad, 2004:1104-1121).

**Systems of Medicine in Andhra Pradesh**

The Government of Andhra Pradesh has four systems of medicine, namely Allopathy, Ayurveda, Homeopathy and Unani (GOA.P Directorate of Medical Health: 2011).. As per 2011 statistics the details of the hospitals that function under each system of medicine are given below:

1. **Allopathy**: It is the conventional form of medicine using pharmaceuticals and scientific techniques for diagnosis and treatment. There are 332 general hospitals, 39 special hospitals, 1626 PHCs and 319 dispensaries under the government control.

2. **Ayurveda**: It is one of the ancient systems of medicine being practised till today. Ayurvedic drugs are soft, prepared from natural sources like herbs and minerals. There are 7 hospitals and 551 dispensaries which function under Ayurvedic medicine.

3. **Homeopathy**: It is a rapidly growing system which is being practised all over the world. Homeopathy came to India in the year 1839 which became a household name due to the safety of its pills. The statistics reveal that, there are 6 hospitals and 284 dispensaries in Andhra Pradesh.

- **Unani**: In India, Unani medicine was introduced in 1351 A.D by Arabs. There are 5 hospitals and 193 dispensaries in A.P (Directorate of Medical Health:2011).

**Meaning of Hospital:**

Many health problems require a level of medical treatment and personal care that extends beyond the range of services, normally available in the patient’s home or in the physician’s office. Modern society has developed formal institutions i.e., hospitals for patients care intended to meet the more complex health needs of its members. Hospital is
the major social institution for delivery of health care in the modern world which offers considerable advantages to both patient and society. The word “hospital” is originated from Latin “Hospes” The term has been used to refer to an institution for the aged, sick, and a place of rest (Arun kumar, 2000:5).

The Hospital is an integral part of social organization. Its function is to provide complete health care for the population both curative/preventive and its out patient services reach out to the families and home environment. The hospital is also a center for training of health workers and bio-social research. The hospital is a media through which scientific technological innovations of medical sciences are put into operation and practised for healthy living of the community. So, today hospital is a place for the treatment of human illness restoration of health and well being of the people. (Syed Ameen Tabish, 1998:156).

As per the medical dictionary, “Hospital is an institution that provides medical, surgical and psychiatric care and treatment for the sick or injured” (Oxford Advanced Learners dictionary, 7th Edition: 2005).

According to Britannica Encyclopedia, “Hospital is an institution for diagnosing and treating the sick or injured, housing them during treatment, examining patients, and managing child birth. Patients can leave after treatment, come in for emergency care or are referred for services not available in a private doctor’s office”. (www.britanica.com).

**Historical perspective of Hospitals in India:**

The most primitive form of the hospital might have been the cave in which early man gave refuge to his companion in despair. In ancient culture, religion and medicine were interlinked.(Heraold E-smalley, 1982:7). The evolution of hospitals in India can be divided in to 3 phases. They are;

**In Ancient India:** In the early period institutions were created specially to care for the sick. King Ashoka founded 18 hospitals all over the Mauryan empire in 230 B.C which
were maintained by the state. There were physicians, nursing staff, and the expenses were borne by the royal treasury. Hala, a scholar in Sathavahana Kingdom in 2nd century B.C wrote about the medical practices of those days in his book “Saptarathi”. The Pallavas, Cholas of the south, the Chanakyas and the Rastrakuta’s of Deccan gave grants to physicians and dispensaries. During the western Chalukyan period (8th-12th century A.D), there were evidences for hospitals and medical care. The inscriptions on the walls of “Tirumukundal” temple in Changalpet mentions about Sri Veera Choleshwara hospital with 15 beds, in 12th -13th century A.D. Under the patronage of Kakatiya’s of Warangal. Vishveswara Shiva had founded a hospital (Arogyashala) and a maternity center in Orugallu in 14th century (Sakharkar B.M, 2009:7).

**In Medieval India:** The Muslim conquerors of India brought with them Hakeems and Arabic system of medicine which is called Unani, which had developed a high standard of care during the 8th-12th century A.D. The Delhi and Deccan Sultans established Unani hospitals (Dar-u-Shafa) all over India during medieval age (Bhatia S.L, 1977:175).

**In the Modern era:** The Western Medical System came to India with the European merchant companies. In the 16th Century, hospitals were established by the Portuguese in Goa during the time of Alfonso de Albuquerque, (1509-1515 AD) but it was in the 18th century that the modern hospitals were staffed with physicians and surgeons to attend to the medical needs of sick people. The first modern hospital in India was established at Madras (presently Chennai) in the year 1664, subsequently at Bombay (presently Mumbai) in 1676 and at Calcutta (presently Kolkata) in 1707. Christian missionaries who came to India did an excellent work for the establishment of modern hospitals throughout the country. In 1883, Dr. Anna Sarah Kugler founded a hospital in Guntur (Andhra Pradesh) and in Tamilnadu the well-known Christian medical college hospital, at Vellore was established by Dr. Ida Scudder. She opened a one-bed clinic in Vellore in 1900. In 1902, she built a 40-bedded hospital. In 1909, she started the School of Nursing and in 1918, a
medical school for women was opened under the name “Missionary Medical School for Women”. In the late 20th century a number of for-profit hospitals arose enormously. (Ratna Vani G, 1991:16)

**Special features of the Hospital:**

1. The motto of the hospital is ‘service’ which cannot be quantified 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.
3. Medical services are rendered by the doctors, nurses and other specialized personnel according to the needs and requirements of each individual.
4. Hospital service is normally emergent in nature and no two situations are similar, which needs the same treatment.
5. The wide spectrum of people involved in the hospital activity ranges from highly skilled professional to a person who may not have visited school at all.
6. The dual control through means of professional authority in the hospital variably leads to management conflict, which is a peculiar situation every hospital administrator has to face in the day to day operation.
7. A hospital has to be highly responsive to the health needs and service expectation of the community.
8. The work in a hospital tends to be both variable and uneven.
9. There is great concern for clarity and responsibility. The cost of committing a mistake in patient’s care is treated with serious life and legal consequences (Syed Ameen Tabish, 1998:156).

**Classification of Hospitals:**

The modern hospitals can be classified on the basis of different criteria including length of stay, type of services offered, control of ownership, levels of care and the teaching institutions or non teaching institutions.
Based on the control and ownership hospitals are of 3 kinds. They are

1. Public or Government hospitals: Run by the Centre, State or Local bodies on non-commercial basis.
2. Private hospitals: Generally, owned by an individual doctor or group of doctors on commercial or sometimes on charity basis
3. Corporate hospitals: This is the latest trend which runs under public limited companies Act. They run on commercial lines. They may be general, specialized or both. (Goyal R.C, 2000:15)

The activities of most hospitals can be grouped into three broad categories:

1. **Clinical services**: Include direct patient care activities such as medicine, surgery, psychiatry and nursing.
2. **Administrative services**: Administrative services include engineering, supply of equipment, medical administration, hospital housekeeping, fiscal and personnel
3. **Allied health services**: Allied health services include dietetics, pharmacy, social work, voluntary service, audiology and speech pathology, prosthetics and medical illustration.

**Significance of Hospital Administration:**

The term “Administration” has been derived from the Latin words ‘ad’ and “ministiare” which means to serve, to care for. In simple language, administration means “the management of affairs”. Administration may be defined as a co-operative group effort to accomplish common goals. It plays an important role in mobilization and proper utilization of material and human resources to achieve the desired ends. Administration is thus a goal-oriented, purposive and co-operative activity which is necessary for smooth running of every institution. (Naidu.S.P, 2006:3)

A hospital is no exception to this fundamental rule. Administration plays a vital role in the functioning of a hospital, more than it does in any other institution. In order
to perform its functions efficiently, hospitals today must be organized and administered in a scientific manner. There is now a greater need for efficient administration in Indian hospitals because the number of people who utilise hospital services has increased manifold, whereas the financial and other resources available to hospitals in India have not kept pace with the growth in number of users. The optimum use of resources is possible only with an efficient and professionally competent administration. This demands that every member involve in hospital administration need to be adequately trained. Moreover, with the increase in the hospital’s size and complexity, as also with the changing socio-economic conditions, the organizational relationship within the hospital has undergone a change. In short, having become a large scale organization, the hospital requires a more explicit organizational division of labour and more efficient and responsible management. (Goyal R.C, 2000: 65).

**Importance of the study:**

Hospital administration is a science and the art of application of the principles of public administration. It deals with matters like promotion of health, preventive services and medical care, development of medical education and training. Dr. S. Krishna Swamy the former Director of National Institute of Health Administration and Education (NIHAE) which is responsible institution for conduct of seminars, conferences, group discussions and research studies of administrative practices in India, has felt that health administration is a crucial area for research since health administration is lacking research based literature ( Krishna Swamy, S, 1975: 415). His statement is very much true, because very few studies were conducted on health administration. Still adequate research work has to be undertaken in this regard, mainly on the administrative and human resources practices of hospitals. The success of a hospital is generally measured in terms of patient care, efficiency, experience of personnel and community service. Absence of any one of these requirements leads to failure. The administration is mainly responsible for success and smooth operation of the hospital. The administration should be available, approachable and
be ever willing to meet and listen to the staff and the patients, and should be ready to do anything that is for the good of the hospital.

In India the private sector participation in health care is on the increase because entrepreneurs and technocrats see immense opportunity for earnings in this sector. Many corporate hospitals and nursing homes have come up. These institutions are following different governing models to render effective and specialized services to the patients, so there is need to conduct adequate research on the administrative practices of the present modern hospitals. The main focus of the present study is to understand the similarities and differences between government run and private owned hospitals administrative patterns.

**Scope of the study:**

The present study examines the administrative practices, human resource management, public private partnership and the patient’s satisfaction aspects of the Government and Corporate hospitals which play a major role in health administration in Andhra Pradesh. The study is taken up in the city of Hyderabad, the capital of Andhra Pradesh, India. Hyderabad is selected as a sample area, since many important government hospitals and notable corporate hospitals exist here and it is accessible to the scholar as she is resides in the city.

Hyderabad is 400 years old city and it has been growing largely in all fields, with more than 85 lakhs of population. Spreading in with 650 square kms; its annual income is half of the state income. Hyderabad situated on the deccan plateau, has an average elevation of about 500 metres above sea level (1,640 feet). Most of the area has a rocky terrain. There is a lot of cultivation in surrounding areas with paddy fields and other crops. The original city of Hyderabad was founded on the banks of river Musi. Now known as the historic "Old City", home to the Charminar and Mecca Masjid, it lies on the southern bank of the river. The city center saw a shift to the north of the river, with the construction of many government buildings and landmarks there, especially south of the Hussain Sagar lake. The rapid growth of the city, along with growth of neighboring municipalities
has resulted in a large and populous metropolitan area. Hyderabad has a tropical wet and dry climate, with hot summers from March to June, the wet monsoon season from July to October and a mild, dry winter from November to February. Annual precipitation is around 79 cm. Temperatures range from the lowest minimum of 12 Deg C in winter to 41 Deg C in summer. (www.ghmc.gov.in accessed, 10-03-2011)

OBJECTIVES OF THE PROPOSED STUDY

The present study is conducted with the following objectives:-

1. To examine the administrative and management patterns of multi-specialty Government and Corporate hospitals.
2. To study the growing importance of human resource management in selected hospitals of “Greater Hyderabad” in Andhra Pradesh.
3. To study patient’s satisfaction levels in both sector hospitals
4. To understand the public/ private partnerships between the Government and Corporate hospitals in the implementation of community health programme such as “Aarogya Sri”.

HYPOTHESIS:

The following Hypothesis has been formulated for the present study:

1. There is a strong relationship between quality of treatment and administrative system.
2. Promptness and flexibility in administration is possible with decentralization and delegation of powers. Formal channels and centralization leads to delay.
3. Quality of hospital care is possible with professionally trained and motivating administrators.
4. Government hospitals are service oriented, whereas corporate hospitals focus not only on better treatment but also Profit orientation.
5. “Aarogya Sri” programme is a savior to the poor in A.P and a good example of Public private partnership.

Research methodology:

Research design: The present study is an attempt to give descriptive and diagnostic analysis. The descriptive research includes fact findings, enquiries of the administrative patterns of government and modern corporate hospitals. The analytical research on the other hand involves collection of data through interviews and questionnaires.

Sampling Area and size: There are 23 districts in A.P excluding Hyderabad. The present study is confined to the city of Hyderabad, the capital of Andhra Pradesh. The city has been selected to conduct research work, since many noted Government and Corporate hospitals are located there.

For the present study purpose all major Government and Corporate hospitals in the city are listed in alphabetical order and two hospitals from each side have been selected in simple random method. These four hospitals are involved in teaching with super specialties treatment and bed strength is more than 350. The distance between the hospitals is at least 10 kilometers, serving different areas of the city.

The hospitals from government sector are

1. Osmania General Hospital, Afzal Gunj, Hyderabad.
2. Gandhi General Hospital, Musheerabad, Secunderabad.

The Corporate Hospitals are

1. Apollo hospitals, Jubilee hills, Hyderabad
2. Krishna Institute of Medical Sciences, Minister’s Road, Secunderabad.

Total 200 respondents are selected as sample size i.e., 50 respondents from each hospital. Out of 50 respondents of a hospital, 5 administrative officials, 25 staff members, and 20 patients from different wards of the hospital.
Techniques used for the data collection:

The study is based on both primary and secondary sources of data.

Primary source of data: The two tools were used in qualitative research to collect the required information, such as:

- Observation method
- Questionnaire method

Focus is laid on observation in selected hospitals. To elicit necessary information, the researcher personally visited all the sample hospitals several times, to observe the conditions and understand the details about health care facilities and patient’s satisfaction. A questionnaire is used to collect the required information from officials of the hospitals at various levels, to get insight and assess the perceptions and motivations for their job satisfaction.

Secondary source: Data from books, journals, websites, government publications, reports, newspapers and handbooks were used.

Formulation of questionnaire:

According to the objectives and nature of the study, three different questionnaires are prepared, one for administrators, one for Staff, and another one for patients. The same kinds of questionnaires are distributed in both government and corporate hospitals.

The administrator’s questionnaire contains four sections; the first section covering qualifications, training, functions and role. Second one dealt with human resources and their perceptions on user charges, public private partnership projects like Aarogya Sree etc. The questionnaire contains both closed and open-ended questions to allow the administrator to express his own feelings.

There is another type of questionnaire that is prepared for the staff of government and corporate hospitals. It consists of three categories of questions, such as qualifications
experience; gender, their interactions with hospital administration/ management and human resource issues.

A structured interview schedule is prepared for the patients to know their economic, social, literacy status issues, satisfaction levels and their perceptions about user charges and diagnostic tests offered in the hospital and Aarogya sree project. The questions were translated into Telugu and Hindi orally for the sake of patients understanding. Verbal consent was taken from the administrators, staff and patients before distributing questionnaires and interviewing. Apart from these techniques, informal interviews were also taken from some of the Professors, Research Associates and from some elders who are familiar with the hospital functioning.

**Data analysis:** Information obtained from the primary source has been carefully analyzed and tabulated. Data is presented in diagrammatic form to make the study easy and understandable.

**Limitations of the study:**

Some of the limitations for this study are

1) Non co-operation and hostile attitude of the respondents and patients.

2) There could be bias and fear among the staff in expressing their views regarding administration.

3) It is difficult to get an appointment from higher officials like hospital superintendents and CEO’s.

**CHAPTER SCHEME:**

The present study is organized into seven chapters.

**CHAPTER I: Introduction:** This chapter provides an understanding of health, hospitals, purpose of research, importance of the study, objectives, methodology and limitations of the study.
CHAPTER II: Review of Literature: This chapter throws light on the existing literature related to the study.

CHAPTER III: Formal organizational features of Government hospital’s administration: It discusses the details about the organizational structure and functions of government hospitals. It also contains the profiles of Government sample hospitals.

CHAPTER IV: Formal organizational features of corporate hospital’s administration: It describes the details of Corporate Hospital administrative patterns and the reasons for the growth of Private Health sector. This chapter also contains the profiles of Corporate sample hospitals.

CHAPTER V: Aarogya Sri- Public and private partnership: This chapter discusses different types of PPP heath projects with a focus on Aarogya Sri programme which is being implemented in Andhra Pradesh from the year 2007.

CHAPTER VI: Comparative and Analytical aspects of Health Administration and Health care: In this chapter an attempt is made to compare the administrative patterns and human resource practices of Government and Corporate hospitals based on the primary data.

CHAPTER VII: Summary and Conclusion: It Contains summary, findings, and suggestions of the study.
References:

- Bhatia S. L,(1977), A History of Medicine, Management Committee B C Roy National Award Fund Medical Council of India, New Delhi p.175.
- Goel S. L, (2005), Public Health Policy and Administration, Deep & Deep, New Delhi, p.10.
- Goyal R.C,(2000), Human Resource Management in Hospital, Prentice hall, New Delhi, p.15.
• Medical Council of India, (2004), Universal’s Bare Act with Short Notes, Law publishing company.PVT.Ltd, p. 5.
• Park K,(2002), Text Book of Preventive and Social Medicine, Jabalpur publishers, Banaras,p.662.
• Planning Commission of India, 10th Five Year Plan, and 2002-2007.
• Sakharkar B.M, (2009), Principles of Hospital Administration and Planning, Jay Pee, New Delhi, p.7.


• Srinivasan. A. V, (2002), Managing a Modern Hospital, Deep and Deep, New Delhi, p.17.

• Syed Ameen Tabish, (1998), Hospital and Health Services Administration-Principles and Practice, Oxford, New Delhi, p.3.
