CHAPTER THREE

PLANNING FOR HEALTH AND HOSPITAL SERVICES
CHAPTER III

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I Health Planning in Developed Nations

"Today, there is a health crisis in the world. It is due, in great part, to the fact that the expectations for radical health improvements which rose from the promises of the nineteenth century discoveries in medical science and their subsequent development into medical technologist cannot be fulfilled".(1) Organization and planning of health would develop in response to these expectations. And as the crisis grows, health planners seek alternatives to the high technology health care. This process continues still.

Health planning in developed countries focussed mainly on communities rather than individuals. Planners also give more stress on preventive, promotive and
rehabilitative health activities rather than institutional individual and curative treatment. The approach naturally reflects the state of health in these countries.

The U.S. Experience

In the U.S., comprehensive health planning was attended with Federal legislation passed in 1966. It created a mechanism for planning both at the state and local levels. The salient features of this comprehensive health planning are its changed orientation, more emphasis to cover everything that affects their health and less emphasis on technology, or facilities. C.H.P. (Comprehensive Health Planning) aimed more at co-ordinating health activities than creating any special health programme. It recognised that different population groups or geographic areas have different needs, physical, mental and environmental and need to be addressed as a totality.

This is a search for 'Community of Solutions' based on grassroots action Committee. Even though 'Right to Health' is accepted in spirit, there is no general agreement about its universality. The term first appeared in the Congressional records in 1976. President F.D.Roosevelt earlier in 1944 had called for the right to adequate medical care and opportunity to achieve and enjoy
good health. It now covers both curative and preventive medicine and attends both individual and the community.

In the U.S., the bulk of Federal Health Care expenditure is devoted to medical care activities. Less than 2.5 percent of the yearly health care expenditure in the United States is allocated to activities of prevention. The main stress given to health services that are essential to overall promotion of health care, are diagnostic, screening, nutrition and education programmes.

The National Health Planning and Resources Development Act of the USA in 1974 was enacted with an aim to provide a national health planning system by co-ordinating state health plans, health services and health facilities. The act divided the country geographically, into approximately 200 health areas each of which is to serve approximately 5 to 30 lakh people. There would be a governing body for each area. Health System Agency would prepare and implement plans for area-wise health planning.

The U.K. Experience

Health care planning in England is having an almost entirely different set up. Here, the health care planning body is formed in each district. It assesses and analyses
health needs of the district. There are two types of Health care planning Teams in England - permanent teams and 'adhoc' teams.(9) Permanent teams continuously deals with children maternity services, mentally ill and elderly people, while 'adhoc' teams deal with primary health care services. Each Health care planning team relies on the assistance and co-operation of a wide range of professionals in health services. (general practitioners, consultants, hospital and community nursing staff, midwives, home nurses and health visitors, paramedical staff, radiographers, physiotherapists, occupational therapists, hospital social workers and social workers from the corresponding local authority).

Services provided by local authorities in England have a considerable impact on health services. Joint care planning teams have therefore been setup by all Area Health Authorities and relevant local authorities (including social services and education department). The Joint Planning Team covers all aspects of health and social services but is "particularly concerned with ensuring" the correct balance of services for the elderly, the disabled, the mentally handicapped, the mentally ill, children and families and for socially handicapped groups such as alcoholics and drug addicts. (10)
There are 90 Area Health Authority in England and Eight in Wales. Each Area Health Authority acts as an operational authority for the main hospital, community health and the general practitioner services. Area Team of Officers who are of equal standing, draws up planning guidelines for each district and reviews and monitors district performance. It also advises the Area Health Authority on the development of health services in the area.

In CIS (Commonwealth of Independent States) the erstwhile USSR, a small group of experts attends to health planning. The group is aware of public needs and political expendiency. There is no problem in implementing the plan because of authoritarian control within the administration.

Health Planning is an easier exercise in developed countries. These have high per capita income and low rate of population growth. Therefore, planning for the health can be realised to the taste of the nation. With high quality medical care reflecting good life, temptation is ever felt say in Canada, to live beyond its means. The major aim of Canadian health planners is to develop a high quality of medical and general health care, and to make available such care to every Canadian citizen. Health
planning has to pay attention to the geography, economy, education and also to political factors of the country.

II Health Planning in Developing Nations

Planning and administration of health programmes vary in complexity with the size of the country, its population and resources available. Countries, economically poor, have more problems due to limited resources. In developing countries, health services both curative and preventive are primarily a governmental responsibility, whereas in developed countries private practitioners and voluntary agencies play a major role in this respect. The main planning problem in these countries is economic to see, how best to meet needs within available resources. In the developed countries, the main problem seems to be administrative - to see how best to co-ordinate efforts or private organization, and private medical practitioners engaged in health services. (14)

India received its administrative machinery from its colonial master - Britian. However, Health planning in India is less centralised than that of the United Kingdom. (15) Health planners in the Indian context comprise, health experts, economists, administrators and public representatives at the union and state levels.
Plans are finalised on the collective thinking of the experts. Their implementation varies from state to state, according to its potential administrative and economic.

III Health Planning in India

Health planning in India is an integral part of the national socio-economic planning. Planning for health is accepted as an important component in the total development of the country. India has planned from the very beginning, health services as a part of general socio-economic development. The broad objectives of health planning are to strengthen health infrastructure to endeavour eradication of diseases and develop integrated basic health services. This stems from the Directive Principles of State Policy and reflect the spirit of the Constitution.

Health is a state subject, the central government has mainly an advisory and co-ordinating function. The central government has initiated nation-wide health programmes and has been co-ordinating these, along with the overall health services. It has over a period constituted various committees, reviewing health situation and recommending remedial measures.
The Bhore Committee report 'Health Survey and Development' under the chairmanship of Sir Joseph Bhore has been a landmark in the development of health planning. Its proposals form the framework of Indian health planning. These are:

a) No individual shall fail to secure adequate medical care because of inability to pay for it.

b) The health services should provide all, the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.

c) The health programme must lay special emphasis on preventive work.

d) There is an urgent need for providing medical relief and preventive health care to the vast rural population of the country.

e) Health services should be placed as close to the people as possible, in order to ensure maximum benefit to the communities to be served.

f) It is essential to secure the active co-operation of the people, in the development of health programmes by health education.

g) Health development schemes should be in the hands of the people's representatives.
The Bhore Committee proposed a comprehensive long term programme and also a short term scheme called a three million plan operative at a district with three million population. (17) The long and short term programmes (18) are as:

* Primary unit for 20,000 population,
* Secondary unit for 600,000 population,
* District organisation for 3,000,000 population,
* Every Four primary health units: 30 bedded hospital,
* Secondary unit: 200 bedded hospital,
* District hospital: 500 bedded

* Number of hospital beds
  - Existing: 0.24 bed per 1000 population
  - Suggested: 5.67 beds for 1000 population (long term schedule)
  - 1.30 beds for 1000 population (10 years)
  - 2.0 beds for 1000 population (15 years short term) (19)

The Bhore Committee report still continues to be an important document in the field of health care administration, though its implementation was far from satisfactory. Therefore Indian Government appointed another health committee in 1961 under the Chairmanship of Sir A. Lakshmana Swamy Mudaliar with a view to regionalise health care. The main recommendations of the Mudaliar Committee were:
1) Consolidation of advances made in the first two five year plans,
2) Strengthening of the district hospital with specialist services, to serve as a central base of regional services.
3) Setting up of a Regional Organization in each state, between the headquarters organization and the district. This would be in charge of a Regional Deputy Director and Assistant Directors, each to supervise 2 or 3 districts medical and health officers.
4) Each Primary Health Centre would serve 40,000 population.
5) Efforts would be made to improve the quality of health care, provided by Primary Health Centres.
6) An All India Health Services on the pattern of Indian Administrative Services, should be constituted.

The Mudaliar Committee was followed in 1963, by another committee under the Chairmanship of Dr.M.S.Chadah, then the Director General of Health Services, to study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme.

The Committee recommended that vigilance operation in respect of the National Malaria Eradication Programme should be the responsibility of the general health
services. The Committee also recommended that vigilance operations through monthly home visits should be implemented by basic health workers and that they should look after the additional duties of collection of vital statistics and family planning, in addition to malaria vigilance. Three to four such workers would be supervised by a Family Planning Health Assistant.

Recommendations of the Chadah Committee too, were not implemented properly and in 1965, a Committee known as Mukherji Committee under the Chairmanship of Shri B. Mukherji, the then secretary of Health to the Government of India was appointed to review the strategy for the implementation of health programme, especially the Family Planning programme. The Committee's main recommendations were that the basic health workers were to be relieved from family planning work and Malaria activities also to be delinked from family planning activities, so that the family planning programme would get exclusive and better attention by its staff. These recommendations were accepted by the Government of India.

The Central Government appointed different committees at different times to go into different aspects of the problems of health care and health care delivery. Important among these were the Kartar Singh Committee
(1974) which came up with the proposal for the multi-purpose worker instead of the uni-purpose worker, and the Shrivastava Committee (1975) which suggested rural orientation of medical education.

In 1979, the Government of India came up with the New Rural Health Policy. It emphasised the need of strengthening health staff at rural area. A major advance in this direction was to have community health volunteers and midwives, one for 1000 population. There was to be one male and female multi-purpose worker, for 5000 population.

The deliberations of the Alma-Ata Conference (1978) are reflected in the India New National Policy in 1982. It emphasises primary health care, aims to make it affordable, expects participation by community and voluntary organisation and introduces modifications, in medical education and training of paramedicals.

V Five Year Plans and Health Sector

When after independence, India adopted planning for development, due attention was paid to health sector as a component of the overall development. This has been reflected through ever increasing allocations made to this
sector, with successive Five Year Plans. However, percentage allocation did not show an appropriate rise. The first Five Year Plan of 1951-56 provided Rs. 65.2 crores for health development schemes. The main objectives of the First Five Year Plan in health sector were the provision of water supply and sanitation, control of malaria, provision of preventive health care, health care for mothers and children, education and training and health education.

More attention has been paid to health sector in the 2nd Five Year Plan. Health (including water supply and Sanitation) was allocated Rs.219.8 crores out of total plan outlay of Rs.4,672 crores. In the Third Five Year Plan the sum rose to Rs.358 crores, out of the total plan outlay of Rs.8576.5 crores. The corresponding plan provisions during the Annual Plan 1966-69, Fourth and Fifth Five Year Plans were of the order of Rs.325.8 crores, 1080.2 crores and 2349.8 crores respectively. During 1979-80, the expenditure on health items amounted to Rs.726.9 crores while the 6th Five Year Plan saw an amount of Rs. 7422.3 crores spent on the health sector. The Seventh Five Year Plan accepted the goal of Health For all by 2000 A.D. It relies on primarily health care, as the main instrument of action to achieve this goal and covers both preventive and promotive aspects of health
care. The maximum needs programme tries to ensure that an effective co-ordination exist, between health and health related action programme like nutrition, safe drinking water supply and sanitation, housing and education. The Seventh Five Year Plan outlay for Health sector was therefore increased upto Rs.13171.7 crores.(25)

The following table shows the details of allocation of Seventh Five Year Plan on Health Sector.

Table III.1 Seventh Plan Outlay - Health and Family Welfare

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Programme</th>
<th>State/ Uts</th>
<th>Centra- lly sponsored Programmes</th>
<th>Central</th>
<th>Total</th>
</tr>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>HEALTH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Minimum Needs programme/Rural Health</td>
<td>1063.35</td>
<td>33.00</td>
<td>-</td>
<td>1096.35</td>
</tr>
<tr>
<td>2.</td>
<td>Control of Communicable Diseases</td>
<td>474.67</td>
<td>521.50</td>
<td>16.50</td>
<td>1012.67</td>
</tr>
<tr>
<td>3.</td>
<td>Hospitals and Dispensaries</td>
<td>-</td>
<td>-</td>
<td>63.75</td>
<td>-</td>
</tr>
<tr>
<td>4.</td>
<td>Medical Education and Training</td>
<td>-</td>
<td>-</td>
<td>75.51</td>
<td>-</td>
</tr>
<tr>
<td>5.</td>
<td>ICMR</td>
<td>-</td>
<td>-</td>
<td>100.00</td>
<td>-</td>
</tr>
<tr>
<td>6.</td>
<td>Indian System of Medicine and Homeopathy</td>
<td>957.53</td>
<td>2.23</td>
<td>40.00</td>
<td>1283.87</td>
</tr>
<tr>
<td>7.</td>
<td>ESI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
The first decade of planning (1951-1961) laid a stable foundation for future health programmes. Facilities for treatment of the sick were improved, campaigns against diseases like small pox, tuberculosis, leprosy and filariasis made head way, the framework for planning and developing a national water supply and sanitation programme became a reality, and a movement for family planning on a mass scale was set in motion. This decade also saw the establishment of 2565 Primary Health Centres and the hospital beds went upto 18500 making the bed patient ratio of 0.4 per thousand. (26)

The Five Year Plan allocation for health sector (family welfare, water supply and sanitation) was 3.86 percent of the total outlay in the first and 4.59 in the second plan. It went down to 4.1 percent in the third plan. (27) In the fourth plan health sector gained 3.9 percent of the outlay. In the fifth plan the figure further went to 3.2 percent. In the sixth plan provisions for health sector and family welfare were of the order of
3.1 percent and 6 percent respectively. In the seventh plan, for health sector and family welfare, the outlay of amount is almost the same (3392 crores and 32.52 crores respectively) and for water supply and sanitation the amount is 6522.47 crores. Plan provisions for health and allied sectors have been varying throughout the period. This naturally affected effective and balanced growth.

VI Indian Health Policy

"The aim of health policy is to secure a fundamental change in health status of the people, to help break the circle of poverty encircling the masses in the developing world and liberate the population to secure the change that they have chosen and in which they participate."(29) The Constitution aims at the elimination of poverty, ignorance and ill-health and directs the State to regard increase in the level of nutrition and standard of living and improvement of public health as among its primary duties. Health Policy aims at "securing the health and strength of workers, men and women, specially ensuring that children are given opportunities and facilities to develop in a healthy manner".(30)

Indian Health Policy pays more attention to the need for providing primary health care with special emphasis on
the preventive, promotive and rehabilitative aspects. Due to constraints of resources, at present there is not much stress on the establishment of curative centres, dispensaries, hospital and institutions for specialist treatment - A large number of these are located in urban areas of the country. A majority still have to travel a long distance so as to reach the nearest curative centre. The Government of India, appreciating the urgency to restructure health services, therefore evolved New National Health Policy (NHP) in 1982. It was approved by the Parliament in 1983. The comprehensive policy goals of NHP are as under:

1) The National Health Policy aims at taking the services nearer to the doorsteps of the people and ensures fuller participation of the community in health development process.

2) The NHP recognises that, if the quality of the lives of the people is to be improved, their health status must be raised. In this perspective, health development is to be viewed as an integral part of the overall human resource development.

3) A co-ordinated approach is sought to be established among all the health related programmes like protected water supply, environmental sanitation, nutrition, housing and education.

4) The NHP further aims at restructuring health services
preventive, promotive and rehabilitative aspects of health care and establishing comprehensive services to reach the population in the remotest areas.

5) The programmes would be implemented through the fullest involvement of the community, thereby realising better community participation.

6) The NHP would integrate health plans with efforts in health related sectors and with their socio-economic development efforts.

7) It would identify and deal with priority the problem area in health.

The National Health Policy thus provides a broad framework for planning and co-ordination while implementing the health policy.

VII Formation of Health Planning

"Health Planning is a phase of the total process which leads from the policy statement to the concrete identification of the populations, whose needs and demands will be served, the indication of the types of activities that would be performed for those population, with their general attributes and the specifications of the types of instruments that would be required to carry out the activities". (31) Planning process not only supports
politico-administrative decisions, but helps to modernize the state of affairs. It is based on a careful analysis of the implementation of health programmes and the attainment of policy-goals in the broader context of development process. As such health planning is related to many factors and is not an independent work. It is an integral part of the overall socio-economic development. Health Planning as planning in other areas is a rational process which involves a number of steps, arranged systematically. It is a highly complicated process, though all steps may not be explicit in all the countries.

The following figure shows different steps in health planning according to the order:

Illustration III.1: Health Planning Process
Effective health planning would depend upon the policy of the government. Each government has its own health policy, framed by the political authorities and is expressed in health legislation enacted by the legislature and administered within the limits of administrative capabilities and skills. Analysis of the present health situation is crucial in any health planning. This is based on the following data.

a) The characteristics of population. It also deals with cause of death statistics, morbidity data, environmental data responsible for the problems of environment threats to health and cultural background.

b) Data on health facilities such as hospitals, clinics etc. (Public, private and voluntary), their geographical distribution and utilisation by the community.

c) Data on available resources personnel, material and financial.

d) Data on training institutions for health personnel.

e) Data on nature and functions of health organisations.

The data so collected would serve as a base for health planning. On the basis of the projected data, one can enumerate health problems which need to be tackled by perspective plans. After identifying health problems, planners would select priorities. This becomes essential
as developing countries suffer by a severe resource crunch. Pressing needs and relatively urgent problems need to be attended first. This step is guided by cost-benefit analysis and cost effectiveness. Cost relates to expenditure incurred to prevent death and to provide health care to the patient, while benefit means contributions made by the person patients (money value of production) thus, saved from death, Cost effectiveness depends upon the adoptability of people and available technical competence.

The next step in health planning is the 'Definition of Goals and Objectives'. Goal is the destination of direction in which the plan is to proceed and the term is used more with reference to long term planning. A goal is usually described in terms of (a) What is to be attained, (b) the extent to which it is to be attained, (c) population involved (d) the geographic areas in which the proposed programme would operate and (e) the length of time required for achieving these goals. Whether as objective is a precise statement of the ends, intended to be achieved, Immediate objectives are further divided into effort objectives and performance objective (targets).

The next major stage in health planning is writing up of the formulated plans. This may contain a schedule (time sequence for activities in the plan to be implemented) and
a procedure (a set of rules for implementing the plan) and other details, so that evaluation would become easy and meaningful. Implementation is an integral part of the planning process. It covers responsibility for translating the objectives of health plan into actions. Plan implementation needs co-operation, co-ordination and commitment at all levels of the implementing machinery. Monitoring management planning is the next important step in health planning. In developing countries, there is a large gap between planning and implementation. Monitoring can help to bridge this gap and improve the situation through advance fixing and retiring of targets to be achieved in a short period of time.

Evaluation is the last step in the health planning process. It is a built-in device to measure effectiveness and impact of planning. Evaluation measures the productivity of available resources in achieving clearly defined objectives. It also makes possible, the re-allocation of priorities and resources on the basis of changing health needs.

VIII Community Response to the Health Planning

Success of a programme operated at different levels and covering a large number of people, rests very much on the response of the community, its awareness of the
process of planning, its knowledge of the components of the programme and approval of the objectives and their priorities.

Health officials were asked about the nature of health planning, its major components and finalization of priorities. Even though officials answered these questions, they were, in general, not in a position to clearly respond to these questions. They had varying ideas about health planning but a majority (64%) could not identify major components. Some officers described health planning as a pre-arrangement of the plan according to the government policy. Other described it as a long process which involved a number of stages, and also explained that the whole process shaped according to the needs, culture, geography and common constraints of the people. To some, health planning was as an essential process with available facilities.

Those officials who attempted to identify major components of health planning, came very close to different stages of health planning i.e. analysing of health situation, identifying national goals or national policy of the government and implementation strategy. However, a majority of the officials (70%) could not answer the question.
All the officials responded to the question of deciding priorities in the health programme. Aware of the ground realities in India, they stated that population is the major issue, so it has to be tackled. Controlling the population, or family planning programmes has therefore been the priority programme which deserves maximum attention.

A similar set of question was asked to knowledgeable people (other than the operating personnel). The following table reflects their awareness of the problem.

**Table III.2 Awareness of Health Planning**

<table>
<thead>
<tr>
<th>Questions regarding</th>
<th>No. of respondent answered</th>
<th>No. of respondent not answered</th>
<th>Total respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Planning</td>
<td>21</td>
<td>42</td>
<td>29</td>
</tr>
<tr>
<td>Planning and</td>
<td>10</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>implementation</td>
<td></td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>Co-ordination by</td>
<td>8</td>
<td>16</td>
<td>42</td>
</tr>
<tr>
<td>different agencies</td>
<td></td>
<td></td>
<td>84</td>
</tr>
<tr>
<td>in realising health</td>
<td></td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present status of</td>
<td>30</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>Health planning in</td>
<td></td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>the area, they belong</td>
<td></td>
<td></td>
<td>50</td>
</tr>
</tbody>
</table>

To this group of respondents (42%) health planning was an arrangement of programmes which have to be implemented at the community level. Nation's policy on
health is formulated by the non-officials, and planning process is arranged by the bureaucrats. Some described it, as a process of finding out health problems and identifying urgent health needs of the people. A few of them added that health planning process also involves surveying resources the people and finding out the priority needs that are realistic. According to them, initiating a purpose oriented action is the most significant aspect of the planning process.

Health programmes are formulated at the central government level and are passed on to the Directorate of the Health Service at the state level. The state target is divided district wise and is further divided till it reaches the level of Primary Health Centre - the grassroots level. However very few answered this question (20%).

A few respondents (8 out of 50 i.e. 16%) were able to respond to the questions relating to co-ordination by different agencies in realising health planning. They were not happy with the present situation of the lack of co-ordination between different operating agencies and therefore very much emphasised the need for such a co-ordinating body. Eventhough effective health planning is not done by the district administration, and that the
district receives the state level break-up targets, the District Medical Officer play a crucial role in its further distribution and implementation. As knowledgeable persons however, an appreciable large number should have responded to these questions.

IX  Health Programming and Implementing Process: Kottayam (District) Kerala.

Directorate of Health Services is the apex body at the State level. It links planning and programming done at the national level and bring it to the district and below level. As the National level, the Union Ministry of Health and Family Welfare prepare guidelines within the frame of National Health Policy and issues directions to the state government indicating priority programmes. Within the state, district is the most important level of implementation. The District Medical Officer (DMO) is overall responsible for the administration in the entire district. He is assisted by the two Deputy Medical Officers along with other district officers in the implementation of various national health programmes at the district. Each district is divided into four or five revenue talukas. Thus, in case of Kottayam district there are four revenue talukas. In each taluka hospital, there is a Senior Civil Surgeon Grade II, who is in overall charge
and who supervises the activities of all health and health programmes in his area. A Primary Health Centre is the grassroots body in the total health care system, in rural areas it is headed by a Medical Officer in-charge, who is responsible for carrying out all the present health programmes.

The following illustration gives the flow of the process of programme formulation and implementation in the administrative setup.

Illustration III.2: Programme formulation and implementation.
Most of the health programmes like Family Planning and Immunisation are prepared at the central level, though a few programmes (which are essential and important for the area) are prepared at the district level (e.g. Health Education, School Health Programmes etc.). Along with the Central Government, State Government also makes provision for health programme (Budget provision under the Ministry/Department of Health and Family Welfare) indicating districtwise allocations.

Each health programme adopts its own way as it is implemented through health institutions. For instance, in the Family Welfare Programme, the work or 'target' is divided and distributed amongst district and taluka hospitals and Primary Health Centres. Each hospital, then distributes, the target among its field staff which is comprised of Health Inspectors, Public Health Nurses and Junior Health Inspectors and Junior Public Health Nurses. The field staff, then collect the list of eligible couple from their allotted area. After collecting the list, they begin extension work, canvass the cause and make people aware of the importance of the Family Planning programmes. They advise on the methods to be used for Family Planning aimed at for a short period or a long and permanent period.
X  **Planning for Hospital Services**

Hospital is a major social institution for the delivery of health care in a society. From the standpoint of society "Hospitalisation 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 the society as a whole". (32)

Modern hospital has become a complex organisation. It concerns with infinite inter related jobs performed by different types of personnel - medical, para-medical, specialised as well as non-specialised. Medical care has now become a team work. Hospital services therefore need efficient planning.

The success of health services equally depends upon hospital organisation. It needs a better organisation as the work is done through the staff at various levels. "All persons who have a part in planning and directing the work of other people use administrative techniques". (33) The common administrative techniques are adopted to the needs and requirements of the situation so that the objectives both short term and long term are achieved. Hospital
services thus need to be planned properly and strategies of programme implementation developed accordingly. Usually these strategies based on the needs of the people, are planned by the central government machinery. While adopting the general principles of management in hospitals administration, one has to take into consideration wards or patient units which are the lowest operating units. A nurse or a ward superintendent must have skill in directing the activity and thinking of a professional co-workers, auxiliary workers and patients. (34)

XI Functions of a Hospital

The main services of a hospital are often described as being four field in character:

a) patient care,
b) Training,
c) Medical Research,
d) Health Education.

(a) Patient Care

Obviously, the primary function of a hospital is to provide services necessary for adequate treatment of patients who are admitted for care. Government hospitals provide services for a wide variety of patients, without any discrimination socio-economic racial. These hospitals
function as a referral hospital, admit patients who come from the bottom level hospitals like Taluka hospital and Primary Health Centres. In general, these hospitals provide preventive promotive and curative services. Hospitals, especially Primary Health Centres have given emphasis on the prevention aspect. The output of hospitals can be measured by the fullness of life, the patient is able to lead on leaving it.

(b) Training

Hospitals have become a workshop for nurses, doctors and para-medical personnel. Intensive training is needed for some of the specialised services like Radiology, Radiotherapy, laboratory. The variety of skills and highly advanced surgical techniques are learnt and operational knowledge about these are acquired mainly in health institutions. A hospital provides this as an in-service education and training programme "to develop such knowledge and skills in all categories of para-medical personnel as are required to make them fit for the job they hold and keep them equipped to the growing needs of their job".(35)

(c) Medical Research

The third broad function of the general hospital concerns with the conduct of investigative studies and research in medical science. Some hospitals have
facilities in the form of medical records of patients for the conducting clinical research. It is true that better professional care of patients largely results from the fruits of research on new problems. An attitude of enquiry and investigation should permeate through the day to day care of patients. Any hospital can develop facilities for research with comparative ease if the staff and administration are properly motivated. It can be done without much extra expenses, whereas elaborate research is expensive.

(d) Health Education

The fourth and final function of a hospital is to support and help, all activities carried out by various public and voluntary agencies to prevent spread of diseases and to promote positive health attitudes in the community through health education. Health education and socio-economic rehabilitation are some of the important functions of a hospital. Health education is carried out by government hospitals through campaigns. A few private hospitals also take part in this programme. Primary Health Centres operating at the grassroots level, have a prime responsibility in this respect. In sum, the main function of any hospital is to promote the health of the community in its wider meaning.
The services provided in a hospital differ from one hospital to another, in the light of the main or group of functions, it is intended to perform. The services can be generally described as line, staff and auxiliary services. All emergency services, out-patient services, in patient services, intensive care unit, services and operation theatres services are known as line services. The procedure in emergency services is as follows:

Illustrationn III.3: Procedure in an Emergency Service
The emergency services provides immediate diagnosis and treatment of the ailment. The case by definition will be of an urgent nature, like injuries from accidents or acute diseases. Serious cases are admitted in emergency wards to provide immediate medical care. In a way, hospital is described by some administrators, as a ship at high seas. Almost all kinds of emergencies that arise in a ship are required to be attended to with little help from outside, so is the case of with hospital. "Some hospital administrators have advised experienced marine engineers on the roll of hospitals. These engineers possess the know how to deal with sudden situation that arise and to be deal without outside help".(36)

The Out-Patient Department (O.P.D) is an equally important service. Minor illness, diseases of serious, acute and chronic nature are examined here. Out-patient services perform one of the important functions which any hospitals is expected to perform. It attends those patients who need attention but who may not require use of bed. The department is separated from the in patient department. However, the out patient department is connected to with laboratory, X-ray department and other supportive services. The Out-Patient Department services can be well explained in the following figure.
In-Patient services follow only after the Out-Patient Department work is over. OPD may advise admission in various wards, according to the type of ailment. Each ward has a duty room, dressing room and other essential facilities needed for in-patient care.

Intensive care unit facilities and operation theatre services are specialised services extended to patients who require acute, multi-disciplinary and intensive observation and treatment. For this duty, the staff needs to be specially trained.
The staff services are also known as supportive services. These comprises Central Sterilizing Equipment Services Management, Diet Management, Pharmaceutical Services Management, Laundry, Laboratory and X-ray Facilities and Nursing Services. Whereas Auxiliary Services deal with Registration and Indoor Case Records, Stores, Transport and Mortuary. These services both staff and auxiliary, are very much important, when the organisation is large and is capable of bearing the expenses of such agencies.

XIII The Hospital - An Organisational Institution

Organization is an integral part of human existence. People join various organisation according to their needs or persuits. It can be defined as a process which identifies each and every job, delegates and interpretes authority and responsibility and establishes relationship between man and man, job to job and department to department. (37)

When one is sick and is treated in a hospital, he as a patient becomes a part of that hospital's organisation, "Hospitals are very complex organisations with a variety of jobs to be performed by different kinds of personnel, specialised as well as non-specialised". (38)
All medical care has now become a team work. "Organisation implies a group of people working in some structured way towards the common ends, which can be called as object of the organisation". (39) Hospital organisation has over a period developed and become complex over a period. A wide variety of specialist posts of non-medical nature, also are a part of this organisation eg., supply officers, engineers, building supervisors, catering manager and the like.

Hospital organisation has many similarities with a typical industrial organisation. Hospitals serve a useful purpose for the society at large and for environmental system in particular. "Health care institutions have a mission - explicit or implicit, in the light of which they set objectives - stated or unstated, to be attained within a time framework. In order to achieve these objectives, they adopt strategies, devise policies, and define the tasks ahead". (40)

A large hospital is a very complex organisation. Its administrator has to co-ordinate different people, staff and components services. People with different types of ailment, personnel with different background staff and auxiliary services need to be co-ordinated by him as a specialist in administration. Each hospital develops its
own profile and works in its own social, cultural and educational background. In this process over a period hospital gets its own personality.

XIV  A Systems Approach

Hospital as an organisation can be better understood as a 'system'. A system is an organised unitary whole comprise of two or more independent parts, sub-systems, and demarcated by identifiable boundaries from its environmental supra system. Thus hospital, like any other organisation is a part of a larger environmental system. Its objectives therefore could be understood within the larger environmental objectives - economic, political or social systems of a state or a country. Health organisation, along with other organisations contribute to the realization of the larger systemic objectives.

The performance of health service can be read as an expression of a sub-system of the larger environmental social system. It would highlight the activities of hospitals as an interaction and expression of health system which realizes the systemic goal of health care and welfare of the community.
The perspective role of hospitals can be understood in a sub-systemic parameter. The role and functions of hospitals may be taken as an 'input' to the larger health system. The resulting interaction that takes place within the overall health system delivers certain 'output' such as health care and welfare of the community. The performance and efficiency would greatly depend on the credibility and strength of the hospitals functioning within the overall health system. The output, in response
to demand, has to satisfy health needs of the clients, as visualised and planned by the officials and the non-officials. The process of feedback regarding overall performance of the system is articulated by these people and shapes the nature and content of the 'input'. Thus hospitals have certain functions which are important for the overall development of the health systems and therefore affect the performance of the environmental social system. (41)

Hospital is like any other organisation is a part of the sub-systems of health, which in turn is a part of the larger environmental system. Within the sub-system, there are specific organisations which perform a component service of that sub-system and are designed accordingly. Just as, a transport sub-system, which realises the movement of men and materials includes various specific organisations - railways - waterways - airways - which forms specific organisation fulfilling a part of the total objective of the transport system and are designed accordingly. In a similar way, the department of health is established to realise the sub-systemic goal of health care and prevention of diseases so that infant mortality can be reduced the life span can be increased and people would be provided with a healthier life which is the ultimate goal of the health system. Hospitals as
organisations help to realise this goal, by realising their own specific organisational goals. Hospital organisation assume more importance in this larger context and becomes a dynamic organisation.

Proper administration of a hospital therefore requires a clear understanding of various dimensions of the hospital's system including the organisational point of view. These dimensions as defined are expected to meet specific needs of society within their catchment area. Hospital administration therefore, requires "blending of technical and administrative competence in the right quality, at the right time, at the right place by the right men and in the right way". (42)

A detailed study of hospital administration, with its managerial framework is therefore significant for the community to attain objectives as it helps to achieve community health goals.
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