CHAPTER SIX

CONCLUDING OBSERVATIONS
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I Health - a Critical Input in Human Resource Development

Health is man's normal condition and his birth right. It is a component of welfare. In a welfare state there will be no place for the five giants namely poverty, disease, ignorance, squalor and idleness. Social policy aims to realise this welfare and health development is integrated with this realisation.

The meaning of 'development' has shifted from economic improvement to the improvement of human resources. This, in turn has resulted in a change of emphasis from buildings and facilities to education and services. It has come to be regarded as a pre-requisite
for optimum socio-economic development. If health development is accepted as an integral part of socio-economic development, it would seem reasonable to provide health services in close association with other social services. In other words, health services now are no longer considered merely as a complex of solely medical measures but an important component of the socio-economic systems. Health thus aims at human resource development, the development of mind as distinct from development of body. However, this realisation is missing in the Third World Countries.

II Plight of Health in Third World Countries

The Third World Countries often neglect their health problems. This neglect, in turn and in the end, affect their socio-economic development. India is no exception even though there are several good achievements to the nation's credit. There is a reduction in mortality rate and an increase in expectancy of life at birth. There is an expansion of medical research and education and along with expansion of health programmes. Communicable diseases are effectively controlled. Similarly Mother and Child Health services have a wide coverage. Family Planning is re-termed as Family Welfare for the wide coverage of the programme. However, failures are equally pronounced even
more than the achievements. The Family Planning Health programme is far from being a success and the population pressure is still considerable. The country has a very long way to go in the control of several communicable diseases that have almost disappeared from the developed countries. The morbidity pattern has not materially changed and the rates of mortality among women and children are still high. Further, there is no programme of health education worth the name. This is the actual health profile which is prevalent in India.

III Achievements in the field of Health in Kerala State

The overall picture in a vast country like India, may thus be gloomy. A substantial change would need mobilization of resources on a much larger scale. But small pockets within the country, through proper management, through generation of adequate resources and through participative techniques can show the way. The state of Kerala is such an example. Unlike, other states of India, the health profile of the state of Kerala in general and Kottayam district in particular is over all good. Popular opinion obtained from the questionnaire also confirms this fact. Through Hospitals in Kerala are evenly distributed throughout the state. The easy access to medical facilities, relatively low cost of medical
services and high demand for them are the contributory factors to better health conditions in Kerala. The birth and death rates are controlled in the State. Similarly the infant and maternal mortality rates are relatively low, compared with other states in the country. Though hospitals especially PHCs are effective community educational centres of health care. A combined effect of this is reflected in the encouraging achievements under the scheme 'Health For All by 2000 A.D.'

IV **Health For All by 2000 A.D.**

The approach towards health problems and health system throughout the world, experienced a significant shift after the Alma-Ata Conference in 1978. The adoption of 'Health For All by 2000 A.D.' as the main objective and the recognition of primary health care as the key to achieve this objective have been the main reason behind this shift. At the national level, the target is yet to be fulfilled. However, in Kerala, according to the reflections of most of hospital officials and knowledgeable persons the picture differs. Here, the targets under the programme have already been achieved, and this achievement is supported by the awareness of the people about the programme 'Health For All' and its
operations. The picture would have been brighter, had there been better co-ordination of activities at the grassroots level, between hospitals in the government sector, private hospitals and various non-governmental agencies, working in the area. The district level co-ordination committee need attend to this problem with all awareness and priority and evolve suitable mechanism to ensure co-ordination. Equally important is, the planning of health so as to reach health programmes to clients at the local community level.

V Indian Experiments in Health Planning

Health Planning is a part of national development planning. It contributes to economic utilisation of materials, manpower and financial resources, though its immediate purpose is to improve health services as such. Health administration in India lacks this perspective and also, the art of health planning. There is therefore the need to training health administrators. In their absence, health programmes receives a low priority. This, not only affects directly or indirectly, health services, their content and expansion but in the final analysis, it affects the manpower planning too.

The present study reveals the fact that even hospital administrators and other higher officials are not aware of
the process of health planning. Planning is a complex process and health administrators have to organise all the relevant inputs for a meaningful health planning. At the district level, there are still a number of weak areas in planning and in administering health development. Administrative issues like co-ordination, communication and inter relationship between the officials and voluntary organisation need be attended to. This will make the administration of planning effective and acceptable.

In addition, planning would be more realistic if it is based on the needs of the people. As ultimate decisions rest with political elites, they should have a clear perception of people's problems. The non-officials views on health problems indicate this lacuna. The political authorities should have comprehensive and accommodative views on such issues irrespective of their political affiliations.

VI Managerial Inputs in the Hospitals

Efficient and responsive planning needs to be effectively administered. Many of the hospital services are becoming complex and technical. This makes a case for managerial inputs in hospital administration.
Outpatient Services

The outpatient service is the most vital and heavily demanded sector of any hospital system, as it constitutes a service to the vast majority of those who come to any hospital. The present day outpatient facilities in the hospital system are far from ideal, in providing even the minimal patient care, leave alone patient satisfaction. The main drawback in the present system is the overcrowding in OPDs. Patients often have to wait for hours to get the doctor's attention. Most of the patients, irrespective of whether they visit private and public hospitals have to wait for more than one hour to receive attention and consultation from the doctors. Similarly, in government hospitals, it seems, doctors spare very little time to hear and ask, examine and prescribe and record each case. The overcrowding causes inadequate concern for the patients. The existing system has become ineffective as the specialists are more often required to treat ordinary diseases, resulting in gross under-utilisation of their specialised skills. This problem often arises in government hospitals, where the low income group and middle income group visit. The following suggestions can be of help to hospital authorities as they tackle problems in Outpatient department.
a) In all government hospitals, the general Out-patient Department should function from 8 am to 1 pm (at present it is from 8 am to 12 noon).

b) Referral services as well as ancillary services should also function concurrently, during the general 'Out patient hour'.

c) All specialised services should be available at Out-patient Department for referral services during the general 'outpatient time'.

d) Nursing and para-medical services should be available for each of the outpatient units.

e) The registering and data keeping work regarding each outpatient case should be vested with the medical record librarian.

In-Patient Service

Well organised inpatient service should help to reduce patients health problems and also add to their mental satisfaction. At present, government hospitals, in Kerala in general and the district of Kottayam in particular, do not have good building and furniture which are essential for a hospital's in-patient services. The in-patient services at the PHC level, are far from satisfactory, and the situation is going from bad to worse at PHC's sub-centres. (even though Kerala leads the
country in health services). The bed strength of Primary Health centres is between 10 to 30, of the Taluka hospital between 125 to 250 and with District hospital, it is between 300 to 350. The present study reveals that this facility is too inadequate to cope up with the huge demand, as a result of high density of population in the state. The In-patient facilities should be enhanced at all the levels of hospitals with a minimum of 10 beds at sub-centre of Primary Health Centres. 50 beds at major PHCs, 300 beds at Taluka hospitals and 500 beds at District hospitals.

Steps should also be taken to provide facilities to the hospitals such as:

a) basic amenities, power supply, toilet and sanitation, canteen, public telephone system transportation etc.
b) equip wards with physical amenities like proper beds, mattresses and accessories like wheel chairs, trolleys etc.
c) provide general intensive care unit with round the clock service, attached to the PHC, Taluka and District hospitals.

Besides these, efficient management inputs would help every hospital to achieve its goals. In this context Co-ordination plays a vital role in improving the
functions of a hospital system.

Co-ordination

Health is a sub-system of the overall socio-economic system. The achievements in the area of health are therefore closely linked with the co-ordination and support from various other sectors such as education, social welfare, panchayat, electricity, Public Works Department and Rural Development. Many of the health programmes of hospitals require a close liaison with these departments. Hospital administrators in this context, play a crucial role in co-ordinating different tasks and efforts by the different agencies and departments. An awareness and acceptance of the importance of co-ordination is a pre-requisite. This alone, however, may not produce any desired result, unless hospital administrators make conscious efforts to work out appropriate strategies and establish linkages with other sectors, in the functioning of hospitals. Their co-operation is equally imperative to arrive at good policy decision, and to achieve good results.

During the course of interviews with hospital officials, this issue was discussed. It is a good sign, that they agree with the importance of coordination. The non-officials raised some issues pertaining to
co-ordination the lack of which acted as a constraint in the implementation of health programmes. According to them, the main obstacle in coordinating health programmes has been the problem of functional co-ordination. In their view, hospital administrator is the only person, who can co-ordinate the work of different persons and departments.

These responses further reveal the need of a separate co-ordinating body at the district level. Hospital administrators are busy with organising medical care and other programmes and hence they would be unable to spare time to work for co-ordination between various departments and voluntary agencies. Even though there exists a steering committee and a Technical Committee at the State and district level, it is not adequate to cope up with present problems. Therefore, a new co-ordinating body comprising of members from health officials, non-officials and non-voluntary organisations need to be set up.

Delegation and Supervision

Along with co-ordination, delegation of powers to hospital administration would make it efficient and effective. It would also enlarge administrators functional capabilities. As powers are not adequately delegated, the end effects is over burdening at the higher level and
underadministration at the lower level. This is reflected at all the levels, District, Taluka and at the level of PHC. Delegation would not only relieve the health administrator but it would help develop subordinates' abilities. The administrator can relieve himself of some procedural work with implementation of a well-trained programme. His subordinate, through such delegation can build up his capabilities.

Along with delegation, proper supervision an equally important managerial input, is essential for better administration of health programmes.

The hospital administrator should himself set a good example before his subordinates in punctuality, temperament, efficiency, initiative and tacts. However, he falls short of the expectations, in both the private and public hospitals. Partly it is due to overwork in the absence of delegation. But it is more, due to lack of managerial skills, expected at this level. Hospital administrators are medical professionals by training. Basically practitioners, they lack exposure to managerial skills. Slackening of supervision has also been reported in the study.

Cooperation and coordination, understanding and interaction amongst various levels of administration
would help hospital administrator to effectively supervise
the work. Since supervision is an art as well as a
science, hospital administrators have to develop special
supervisory skills in relation to the work, as the process
of implementation very much relies on effective
supervision.

Implementation Process

Planning, co-ordination and supervision collectively
tone up the process of implementation. Such a process
only, would help the administrator to reach the people.
The major ingredients of the implementation process are:

a) Broad programming:
It gives the authority, a broad frame work of
objectives and responsibilities assigned to hospitals.

b) Detailed Programming
It helps to convert these responsibilities into
specific action plans, fixing monthly or quarterly targets
and re-designing and delegating responsibilities as
required.

c) Implementation
It is the translation of the detailed programme into
actions in the field, day to day activities managed and
d) Evaluation:
It assess the programme in terms of its impact.

e) Re-programming:
It helps to modify the programmes on the basis of evaluation. The present picture shows a serious lack of information support at the implementation level. Such support would make implementation effective and evaluation clear and specific.

Illustration VI.1: Implementation process with information support
The relevance and validity of the broad programming of a function becomes weak if the implementation level is weak. Many crucial issues are involved at the implementation stage. Each in its own way, affect implementation of health programmes. Achievements depend upon leadership qualities of the hospital administrator his commitment to the work and the faculty of motivating others; which helps him to secure support from his colleagues, both medical and para-medical and co-operation from his field staff and acceptance of his services from the people at large. This support and co-operation is reflected in better performance of the programme. Co-ordination of efforts from other government department ensure this performance, while the non-officials ensure its extension.

To take the first, commitment, motivation and leadership qualities of an administrator are a crucial requirement. This depend upon a host of factors, such as a) the realisation of one's own social responsibilities b) perception about one's role in the system c) the rewards or encouragement, one receives while performing tasks and d) the support one receives from colleagues and authorities.
The interplay of these factors affects individual attitudes which in turn are reflected in one's performance. Primary Health Centre in Kottayam deserves mention in this respect. Here a doctor couple has set an example as to show how best the work can be done against odds and how encouraging results can be produced. In terms of infrastructure facilities, the condition of this Primary Health Centre is very poor, so is the situation, in terms of adequacy of field staff. Yet when it comes to achieve a target, its rank has always been among the best. The credit for this goes to the young dedicated doctor couple; that provides inspiring leadership. Such a committed leadership was also noticed at a few government hospitals in the district which highlight the leadership role of the hospital administrator.

The Hospital superintendent or The Medical Officer cannot function in a vacuum. He needs support from colleagues, superiors and field staff, which again depends on several extraneous factors. While there is harmony and understanding with their professional colleagues, the relationship between hospital administrator and the field staff is not that smooth. Tensions arise mainly due to administrations.

a) inability to provide basic facilities to field staff (especially to Public Health Nurses who work in remote areas)
b) inability to control and supervise the functioning of field staff, due to heavy work load.
c) political interference when disciplinary actions are initiated, and
d) lack of motivation amongst the field staff due to poor working conditions and lack of incentives.

Equally crucial area is popular support, people's acceptance and involvement in the programme. This has been a general drawback of health campaigns. However, district Kottayam is not much affected by this factor. The credit for this, probably goes to the young dedicated doctors working at various PHCs like Paika, Erumely, Ullandu etc. whose names and fame have spread over the district and as such, have become an example to imitate. In the present system, the monitoring of activities follows a similar pattern. Periodical staff meeting is the method to review different tasks. Administration seems to be used to this arrangement. The progress of field staff is reviewed in these meetings. Collective steps are taken wherever necessary. These meetings are also used for issuing new guidelines or advise to functionaries. Here, again, the effectiveness depends, to a great extent, on the level of commitment of the hospital administrator. His leadership gives tone to the conduct of the meeting.
The weak links in the implementation process are evaluation and the resultant reprogramming. Hospital administrators (most of them are medical officers and superintendent) are aware of this need, but they seldom work for it. Or perhaps they are not yet convinced of the need as it is often said about. Even those medical professionals who work with commitment rarely make any modification to practices they have followed for long. It is because of their medical profession's background that makes them to be less appreciative of managerial inputs in hospital administration. Thus the implementation basically suffers from the following shortcomings:

a) doctor's lack of commitment and conviction about the social utility of Primary Health Care.

b) lack of decentralised decision making reducing medical officers of a PHC as mere implementator of programmes.

c) lack of people's involvement in shaping health policies.

VII Hospital Development Committees

A number of health programmes are implemented through hospitals. Among these, Family Planning activities receive the highest priority. Various agencies involved in health activities, also favour family planning programmes as a priority programme over other health services like
MCH, Immunisation and Health Education. Some of these services do not reach the grassroots especially the immunisation services which need to go to rural areas more effectively. Presently child protection campaign and Health Education campaign aim to reach rural level. Private hospitals also keep away from many health programmes and concentrate upon a few like MCH or Health Education. Most of the private hospitals do not carry out even these programmes. At government institutions, all these programmes are guided by Hospital Development Committee.

Hospital Development Committee is functioning at all the government hospitals, District-Taluka and PHC's. Its members are nominated by government from the public at large. It has staff representatives also. Basically monitoring and advising in function, it has often failed to achieve its goal. It has been ineffective. Meeting irregularly, inspite of government directives, the survey reveals that non-officials are not interested in its functioning. Inadequate delegation and inadequate finances add to its irregular style of functioning. The ultimate result is that it has not been able to hold members interest in its effective functioning.

The committees if properly functioning will ensure popular participation and promote mutual understanding and
co-operation between the hospital staff and the people. For this, Government will have to rethink about its present system of nomination of non-officials on these committees. Presently, it is done on party lines. Delegation of powers, monitoring incentives to cover meeting expenses, would make these committees more effective. HDC has a potential to play a crucial role planning and guiding health activities. The survey indicates that HDC can positively contribute to realise participation and co-ordination between medical and para-medical staff and between non-officials and medical officials or which depends the success of a programme.

VIII Critical Areas in Health Care Administration

1) Decentralised Administration

In the existing health care administrative set up, fixing targets for health programmes and their priority are done at the state level. This is particularly pronounced in case of Maternal and Child Health and Family Planning Programmes. Each district is allotted a quota and the District Medical Officers in turn, distribute the quota to each PHC under their jurisdiction. The superintendents of the District hospitals, Taluka hospitals and Medical Officers in charge of the PHCs have
only a limited role of implementing programmes and achieving targets which have been handed over to them from higher levels. The survey firmly reveals the urgency of decentralisation of powers. If implementation process is to be successful, the higher authority has to decentralize its power of deciding the targets, making decisions and assume to itself a supervisory and advisory role.

Creation of a post of Taluka Medical Officer would relieve the burden on the District Medical Officer. The status of the Taluka Medical Officer would be appropriate to be that of Civil Surgeon Grade I (Senior Medical Officer) in view of the fact that he would be supervising the work of Medical Officers of the PHCs who are of the rank of Civil Surgeon Grade II (Deputy Medical Officer). The Taluka Medical Officer will be in-charge of intermediate Hospital situated at the Taluka Headquarters. He would be vested with powers of supervision and control not only over the staff working in the Taluka hospital, to which he is attached but also over the staff of the PHCs. From the administrative point of view, it is necessary to redefine the roles of the District Medical Officer and to decentralise administrative powers to grassroots level.

2) Professionalisation in Hospital Administration

Secondly, the study reveals the need for professionalism in hospital administration in health and
medical care has become complex. When a hospital needs services of professionals on medical side they also very much need similar services of professionals on management side. In the present system, medical professionals, who are in charge of hospital administration, find it difficult to appreciate importance of administrative skills that help to realize organizational goals and equip themselves with these skills. Within the decentralised administrative set up hospital administrator also can play a vital role in extending the health services. The administrator who specialises in managerial skills, would improve efficiency in administration than a medical practitioner holding this post.

Considering this problem, it is felt that a cadre of Hospital Administrators should be created so that young and willing medical graduates could be selected and trained and rewarded with out of turn promotions. This process should start from the Directorate of Health Services who is at present a medical practitioner. Also, the creation of a post of Assistant District Medical Officer of Health of the rank of Civil Surgeon Grade II (Deputy Medical Officers) would help the development of a cadre down to the local level. The cadre of hospital administration can ultimately be evolved as the nucleus for the national cadre of Indian Health service personnel (IHS).
At present, Medical Officers become charge officers of Institutions according to the seniority rule. Most of the Medical Officers, who have been all the while been used to clinical work, are not able to do full justice as charge officers of hospital administration. The suggested cadre of hospital administrators, wherein Medical officers are recruited, would take over as charge officers of major medical institutions over a period. They would also be initiated to a course on training in hospital administration at any of the national institutions offering such a course. Such charge officers would be assisted by administrative officers training in management techniques. These officers would be exposed to an orientation training in hospital functioning where they would become aware of the "ethos" of hospital services.

3) Communication System

Thirdly, communication system in hospital administration needs be strengthened. Communication plays a crucial role in hospital administration. The study reveals that lack of information system. Thus if a communicable disease is detected in a rural area, it is the duty of the field staff to report it to the Medical Officer of the Primary Health centre, he in turn has to report it to the District Medical Officer. The District
Medical Officer has to allot medicine and give guidance to the Medical Officer in the Primary Health centre. This remains on paper and the delay results in the spread of the disease which otherwise could have been localized and treated effectively. Therefore, there must be some organisational arrangement to collect process, analyse, interpret and preserve information and make it available to the concerned person whenever needed. Communication system is the 'nerve system' of any administration.

There should be some arrangement to receive and process information on health programmes and make it available to the hospital administrator. This would help him to monitor effectively progress of schemes in his area. If reports from his subordinates are processed at his hospital in tie and corrective action initiated, it would help to avoid the delay. To improve information system at the Primary Health Centres and at Taluka and District Hospitals level, the following measure may be given consideration:

A technical study team should be appointed to make evaluation of the existing communication system at various levels of the hospitals. It should evolve a procedure to make the communication system more purposive, accurate, timely and responsive to all levels of health services
department. The forms should be brief, highlight salient information which could be processed statistically. Such a system under the control of a professional administrator would yield optimum results.

4) Community Participation

Fourthly, community participation is imperative for the successful implementation of all health programmes. The crucial role of community participation has been recognised by the Alma Ata Conference, which had declared that 'people have the right and duty to participate in the process of improvement and maintenance of their health'. In fact most literatures on primary health care, refers to the significant role of community participation.

A majority of the respondents under the survey acknowledge the importance of community participation. Involvement and participation of people in health programmes is significantly related to the success of a programme. The study however reveals that the question of community participation has not been visualized in the proper perspective by many of the officials. The concept is still ambiguous to them because it is seldom discussed or explained. They confuse participation with the response they receive to some of the programmes they implement. The
reason why individuals and families should assume the responsibility of their own health and welfare, and why and how they should develop capacity to contribute through this to their community development are yet to be stated precisely. The concept as well as strategies of community participation, it is felt, should find adequate coverage in the training programmes for medical officers. There are of course, many pre-requisites to attain an ideal level of community participation. A truly voluntary involvement and the sense of responsibility to the community at large, do not materialize unless there is a real devolution of authority and responsibility.

In the present set up, when priorities control manpower and budgetary allocations in hospital organisations are decided at the higher level, it is not possible to involve the community in a meaningful way. It will not be an exaggeration to say that the present mode of implementation of programmes concentrates only on extending the existing health services surfacially and not penetrating and reaching the poor. Instead of helping the poor to organise at family and community level and to take greater control over their lives and health, hospitals now function as a centre to perpetuate dependency of the poor on the existing institutions. The way out of course, does not lie only in the hands of medical professionals who
manage hospitals. The initiative should come from the policy making level, supported by legislative measures and adequate provisions for resources. Creative and extensive involvement of non-governmental organizations in administering health care schemes would make programmes more participative, more community oriented. Kerala in general and the study district Kottayam in particular, scores well on this point.

IX Epilogue

The present model of health services is a centralised and a bureaucratic model. Successful implementation of health programmes on the other hand needs a decentralised and participatory support to the administrative set up where a hospital administrator is more a manager than a medical professional. Quality of health services is important but it is not all. Health care differs from other societal activities or programmes. Here expectations of common people have a priority over technical competence. An abiding spirit of social services and a concern for humanity have a bearing on health activities. When a fuller utilization of health services is aimed at through community participation administrator imbued with social spirit becomes a choice over an administrator equipped with technical competence. A blending of
administrative competence with the already existing technical expertise needs to be aimed at. Such an administrator supported by technical staff would be able to perceive health services in a comprehensive perspective and administer the same, realising the twin purpose-managerially efficient and socially responsive. And it is the latter, that should tone administration and make 'Health For All by 2000 A.D.' more a humanitarian goal than a managerial pursuit.