Chapter-IV
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MANAGEMENT OF GOVERNMENT HOSPITALS

1. ORGANIZATIONAL STRUCTURE

When God created man, he made the human body one of the most complex, yet highly effective and amazingly adaptive organizations of the world. Its each organ does some specialized work, i.e., the eyes see, the ears hear, stomach and intestines digest the food, etc. There also exists marvellous co-ordination among all these organs. When hands and legs work, the lungs respire more quickly and the heart pumps more blood. There is a central authority in the brain and nervous system which plans all activities, direct the different organs of the body and keeps control. We need similar kind of organization for all human activities including hospitals. The importance of organization has been well-expressed by Lounsbury Fish, when he says, "Organization is more than a chart-it is the mechanism through which management directs, coordinates and controls the business."

1. Basically all organization are alike. But hospital have few distinction as under:-

- Hospital has to be highly responsive to the community's health needs and expectations.
• The hospital work cannot be standardized as in the case of industrial production. Hospital has to render personal care and treatment to individual patients.

• The emergency nature of hospital work places more heavy burden and moral responsibility on organization and members.

• Compared to industrial work, hospital work tends to be variable and uneven instead of planned and stable.

• The nature of hospital work is such that there is less tolerance of errors and great concern for clarity and responsibility. The cost of errors or mistake in hospital in very high involving life and death and legal implication.

• The hospital work is specialized, heterogenous and professional.

• Hospital work is inter-dependent.

• The hospital employee came from different Socio economic culture with different education and class background. Hospital requires close contact and frequent interaction within the organization. Therefore, inter-cadre relationship have to be very effective for carrying out of the objectives of the hospital.

• Hospital working needs extensive Co-ordination of efforts, resources, time and expectations and demands of the community.

The role of hospital organization in health and medical care has also become too complex to permit any administrative concepts of a
generation ago. Even a casual observation of present hospital organization can tell us that the hospital with its various departments services, various professional groups and multiple relationship in its heterogenous group in unique organization. Therefore, it requires the services of professional managers. It should be now realized that simple dedication of medical and nursing staff to good quality of medical care is not sufficient in itself to produce required results, unless there is accompanying understanding of the importance and ramification of the principles of management.

Common objective of today's hospitals in that every individual regardless of race, colour, creed or sex should be assured of that inherent right, i.e., good health. Thus, the hospital organization is not only interested in 'care of sick' but also in the prevention of sickness. In order to perform both these functions efficiently and effectively, hospitals must be organized and managed in a truly scientific manner. It has become more essential as the modern hospital, in addition of their classical function of "care of sick" is broadening their scope of activities into promotive, preventive and rehabilitative services. This demands a sea-change to be brought about in hospital functioning. If the required changes are to be brought about smoothly and sustain them, modern management techniques need to be introduced adequately as early as possible.

At present the hospitals of different sizes all over the country are being managed by the traditional system of senior most
physician/surgeon in the institutions without any formal training in hospital administration. Normally, the senior most officer is made responsible for looking after the day-to-day management of hospital in addition to his/her clinical duties.

“It is natural that these administrators have not taken the responsibilities of administration seriously due to dual responsibilities and dividend loyalties.”¹

The concept of organization structure is somewhat abstract. It refers to the differentiation and integration of activities and authority roles and relationships in the organization. Applying these concepts of differentiation and integration to organization structure and design requires some measures in sequence. These are identification of activities, grouping of activities and authority relationship among individuals and groups.

- **Identification of Activities**: While designing the organization structure, management must identify the various activities to be performed in order to achieve the organizational objectives. The major objective of hospital organization is “care of sick” for which it requires some basic activities on its medical as well as non-medical (managerial) side. On medical side it requires clinical activities, general surgical and specialized surgical activities, anaesthesiological activities, maternity activities,

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nursing activities, pathology and other laboratory activities, radiology activities, pharmaceutical, dental, dietary and housekeeping activities etc. On management side also its requires, financial, personnel, material and other concerned administrative activities.

It should be borne in mind that organization must provide for all these activities without any unnecessary duplication in its design or structure.

- **Grouping of Activities** :- Closely related and similar activities are to be group together to from a department, divisions and sections to make co-ordination easier. Grouping can be done on different bases but for hospital organization it can be based on functions. Then the grouped activities in the form of departments are assigned to various positions. These are occupied by various individuals to whom job assignment are made which create responsibility and certainty of work performance.

- **Delegation of Authority** :- Since the assignment of the job to an individual creates responsibility on his part, he must have corresponding authority to discharge his obligations. Authority and responsibility are co-related. Authority without responsibility is a dangerous thing and responsibility without authority has no meaning.
Organizational relationship can be made more clear through the vital tools like charts and manuals. They give clear idea about work distribution, job assignment, authority, interrelationship between positions and responsibility, etc. Every job must be defined on unambiguous language. When the job assignment is clear, the fulfillment of goals can be self-concentrated with minimum of misunderstanding and confusion, about who is to do what. Otherwise there may arise confusion, clashes and overlapping of authority. Consequently efficiency will be hampered and personal relationship may also be endangered.

It has been observed that the selected groups of hospital organizations are having simple organization charts but they are not accompanied by the manuals. Hence, jobs are not clearly defined. They lack job descriptions and clarity in some of organizational relationship.

The hospital organization is organized at present under the guidance and control of the C.M.O./C.M.S. Most of the selected hospitals prepare their organization charts in a very simple form. A typical organization chart generally prepared by them as given below:-

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Chart No. 4.1
District Organisational structure

Chief Medical Officer (CMO)

- Deputy CMOs for Urban Setup (DCMO)
- Deputy CMOs for Rural Setup (DCMO)
- SMO Stores
- Administration Officer

- MO-IC (PHC)
- Medical Supretendent (CHC)
Chart No. 4.2

Organisational structure of Community Health Centre

COMMUNITY HEALTH CENTRE
1:1,000,000 Population with the specialties of medicine, surgery and Gynae.

PRIMARY HEALTH CENTRE
UNDER THE CHARGE OF A COMMUNITY HEALTH OFFICER
1:30,000 Population

SUB-CENTRES
6 or more with 1 male and 1 female Health Worker
1:30,000 Population

VILLAGE HEALTH GUIDE
1:1000 POP.

TRADITIONAL BIRTH ATTENDANT/DAI
1:1000 POP.

VILLAGE HEALTH GUIDE
1:1000 POP.

TRADITIONAL BIRTH ATTENDANT/DAI
1:1000 POP.

VILLAGE HEALTH GUIDE
1:1000 POP.

TRADITIONAL BIRTH ATTENDANT/DAI
1:1000 POP.
Chart No. 4.3 - Organisational structure of Primary Health Centre

MEDICAL OFFICER INCHARGE

LADY MEDICAL OFFICER

MEDICAL OFFICER (F.P.)

BLOCK EXTENSION EDUCATOR

HEALTH SUPERVISOR
(Male)
Erstwhile categories of health inspectors and sanitary inspectors
1:3-4 MPWs(M)

MULTI-PURPOSE HEALTH WORKER
(Male)
Erstwhile categories of FPFWs, BHWs and vaccinators
1:6000-8000 Population

HEALTH SUPERVISOR
(Female)
Erstwhile categories of lady Health Visitor
1:3-4 MPWs(M)

MULTI-PURPOSE HEALTH WORKER
(Female)
Erstwhile categories of ANMs
1:3000-4000 Population

Dispensers (2), Dresser (1), Nurse Dai (2), Laboratory Technician and/or Laboratory Assistant (1), Computer in-charge (1), T.B. Worker (1), Driver (1) and class IV staff.

Areas amongst the MOs is required to be divided for monitoring and supervision purposes.

To assist the MOs in general way in respect of all Health Programmes.

Sub-centres to be established at the ratio of 1 SC for 8000 population. The concept of intensive a twilight areas for coverage in the case of MPWs (Female) to continue for time being.
The organisational structure differ on the basis of their size. A big hospital may have the following structure:

Chart No. 4.4 - Organisational structure of more than 400 bedded Govt. Hospital

- **Doctors**
  - Wards
    - Casualty & Emergency services
    - Neurosurgery
    - Nephrology
    - Orthopaedics
    - Urology
    - Endocrinology
    - Dermatology
    - STD
    - CSSD
    - Others
  - Radiology & other services
  - Plastic & Cosmetic Surgery
  - Neurology
  - Orthopaedics
  - Psychiatry
  - Out-patient
    - Ward boys
    - Ayahs
  - Matrons
  - Senior Sisters
  - Staff Nurses
  - Probationary nurses
  - Auxiliary nurses
  - Daces (midwives)

- **Nonmedical**
  - Administration
    - Lay Secretary
    - Purchase officer
    - Office Suptd.
    - UDC
    - LDC
    - Class VI Employees

- **Clinical**
  - Nursing Suptd.

- **Medical**
  - C.M.O.
    - Superintendent
    - M.O.
  - Support Services
    - Pharmacy
    - Dietary
    - Biomedical
    - Engineering
    - Laundry
    - Waste disposal
    - Transport
    - Ambulance
    - Other services
The organization chart is not accompanied by manuals which can defined each job and explain the concerned activities, authority and responsibility in writing and in unambiguous terms.

Hence, there are no 'Key tasks' set out for different jobs. In views of one of the C.M.O. "It is not even possible of set out key tasks and job description for doctors in all the cases.

2. GENERAL ADMINISTRATION

Health administration is becoming complex day-to-day. Man is acquiring undreamt of powers, for scientific progress makes him everyday more capable of shaping the world and his destiny. He has the potentiality to bring about socio-economic revolution for the harmonious and healthy development of the people. The world has the resources and know-how to achieve a significant improvement in health care. But improved health will not percolate to the majority of the people as a natural consequence of economic growth. It requires an efficient administrative and managerial system to translate the benefits of science and technology to the people. Unfortunately, developing countries have failed to produce the expected system. The weakness, ineptitude and general inefficiency of their government system are massive obstacles not only in their development but even in their survival.

Public health administration is an area of activity which calls for specialized knowledge and techniques which can help the people to
achieve the health care. Until and unless, we understand all the implications of such an administration, we may not be able to reap the potential benefits of health organizations. This is a definite art which can be learnt and practiced to produce pre-designs output. Health administration is an art as it can help to direct and guide the efforts of those involved in such an enterprise towards some specific ends or objectives efficiently. These are a great need to make this art perfect and professional. A professionally efficient and competent administration is able to serve the people better. Besides, the health personnel must be dedicated to their profession. Administration is of the centre of all human affairs. Its principal aspects are formulation of policy and its implementation for the attainment in an optimum manner of stated ends in the shape of service or products. Administration is an activity which demands correct analysis and accurate orientation. According to Simon, "In its broadest sense, administration can be defined as the activities of groups cooperating to accomplish common goals."^2

In the words of Marx: "Administration is determined action taken in the pursuit of a conscious purpose. It is the systematic ordering of affairs and the calculated use of resources aimed at making those things happen which one wants to happen—and forestalling everything to the contrary."^3

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^2 H. Simon, et al. Public Administration, p.3
^3 Marx (e.d.), Elements of Public Administration, p.3
In simple words, administration may be defined as the management of affairs with the use of well thought out principles and practices and rationalized techniques to achieve certain objectives. Priffner and Presthus define administration as “The organization and direction of human and material resources to achieve desired ends.”

Administration consists of a structure or an organization of various institutions essential for its functioning; the processes, procedures and interaction of various constituents; and the techniques and skills of human relation. It is the management of human affairs concerned with the need of carrying out specific objectives. Administration is involved in all fields of human endeavour where there is a planned effort. It is a force which lays down the objectives which an organization and its management are to strive for and the board policies under which to operate. Administration provides the means whereby the most effective use can be made of the knowledge and skills of those giving the service. It is a way of conceptual thinking for attaining pre-determined goals through group efforts.

“Health Administration”, is a branch of Public Administration which deals with matters relating to the promotion of health, preventive services, medical care, rehabilitation, the delivery of health services, the development of health, manpower and the medical education and

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*Priffner and Presthus Public Administration, New York, p.3*
training. The purpose of Public Health Administration is to provide total health services to the people with economy and efficiency. Health Administration must use the knowledge of health economics for achieve economy. Three French teachers of Health Economics (Professor P. Bonamour, P. Guyot and D. Jolly) defined Health Economics as:

"That branch of knowledge which seeks to optimize medical action, that is, study ways of spreading the available resources so as to ensure the best possible state of health for the population, within the limited means."  

Efficiency in health administration can be achieved through proper policy formulation and its implementation. Health administration is the force which can help the health system in the formulation of sound health policy and its implementation. One of the best definitions of Health Administration is given by C.E.A. Winslow who defined it as "The science and art of preventing diseases; prolonging life, promoting health efficiency through organized community effort for the sanitation of the environment, the control of communicable diseases, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, the development of

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social machinery to ensure to every citizen a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birth right of health and longevity.”

**Objective of Health Administration**

There are numerous objectives of health administration. The following deserve special attention:

(a) Increasing the average length of human life.

(b) Decreasing the mortality rate, particularly infant mortality rate, due to those diseases which can be easily prevented or remedied.

(c) Decreasing the morbidity rate.

(d) Increasing the physical, mental and social well-being of the individual.

(e) Increasing the pace of adjustment, of individual to his environment.

(f) Providing total health care to enrich quality of life.

One of the basic principles of public health administration relevant both to developed and developing countries should be that

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6 J.J. Hanlon (1964), *Principles of Public Health Administration*, C.V. Mosby
scarce resources, including that of medical manpower, should not be utilized only for the purpose of creating high power clinical establishments to treat rare diseases rather than using them for the successful functioning of public health services to combat common health problems, particularly of vulnerable groups, like, pregnant women, lactating mothers and young children. Similarly, medical education can be reoriented and medical services reorganized with; the involvement and cooperation of political and social scientists.

The developing world is faced with the problems of limited resources, infinite needs and competing demands in the domain of health. In order to provide the health services (preventive, promotive, curative and rehabilitative) to the total population sick and the healthy, the developing world would have to provide an effective system of health administration. If these components are combined fruitfully, it is sure the health administration can deliver the desired goods and services to its constituents:

- **Policy formulation and its implementation**

At various time the government of India appointed committees to examine the existing health condition and health organisation in the country and to make recommendations for the future development. In this process BHORE COMMITTEE was appointed in 1943 and submitted its report in 1946 on eve of India’s independent. The commissions recommendations could not be considered sufficient and
1959 government constituted MUDALIAR COMMITTEE that gave its report in 1962 and another committee call CHADHA COMMITTEE was setup in 1963 to study the arrangement for the Malaria irradiation programme. Again in 1965 MUKHERJI COMMITTEE was appointed to study the family planning programme. Another committee called JUNGAL WALLA COMMITTEE 1967 was appoint in 1967 to give recommendations on integration of health services. Infact up till now separate committee were appointed to give suggestions on the various problems related with the health by appointing JUNGAL WALLA COMMITTEE 1967. The government made an attempt to formulate national health policy. However nothing serious could be achieved in this direction until 1983 when the government of India announced its national health policy. In between in 1973 committee on multi-purpose workers under health and family planning was constituted by the government of India under the chairmanship of Mr. Kartar Singh. Group on “Medical Education and Support Manpower” was appointed in 1974 under the Dr. J.B. Srivastava who submitted its report in 1975.

**National Health Policy 1983**

A statement on the “National Health Policy” was laid on the Table of both the Houses of Parliament on the second November 1982. The National Health Policy was discussed at length in both Houses and was approved by the Rajya Sabha on fourth August, 1983, and the Lok Sabha on 22nd December, 1983. (Refer Appendix III for the Statement
on National Health Policy). The policy lays stress on the preventive, promotive, public health and rehabilitative aspects of health care and points to the need of establishing comprehensive, primary health care services to reach the population in the remotest areas of the country, the need to view health and human development as a vital component of overall integrated national socio-economic development, decentralised system of health care delivery with the maximum community and individual self-reliance and participation. The policy also lays stress on ensuring adequate nutrition, safe drinking water supply and improved sanitation for all segments of the population. The policy sets out specific goals to segments of the population. Sixth conference of central council of Health and Family welfare held from April 8 to 10, 1999 at New Delhi came out with a draft National Health Policy to remedy the weaknesses in the existing National Health Policy. In addition, Government of India has enacted National Population Policy 2000. Which is an attempt to improve the quality of life of the people through population control. The noteworthy initiatives under the national health policy were:

(i) A phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves;

(ii) Intermediation through ‘Health volunteers’ having appropriate
knowledge, simple skills and requisite technologies;

(iii) Establishment of a well-worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level;

(iv) An integrated net-work of evenly spread speciality and super-speciality services; encouragement of such facilities through private investments for patients who can pay, so that the draw on the Government's facilities is limited to those entitled to free use.

NATIONAL HEALTH POLICY (NHP) - 2002

Financial Resources

The paucity of public health investment is a stark reality. Given the extremely difficult fiscal position of the State Governments, the Central Government will have to play key role in augmenting public health investments. Taking into account the gap in health care facilities, it is planned under the policy to increase health sector expenditure to 6 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010. The State Governments would also need to increase the commitment to the health sector. In the first phase, by 2005, they would be expected to increase the commitment of their resources to 7 percent of Budget; and in the second phase, by 2010, to increase it to 8 percent of the Budget. With the stepping up of the public health investment, the Central Government's contribution would rise to 25 percent from the existing 15 percent by 2010. The
provisioning of higher public health investments will also be contingent upon the increase in the absorptive capacity of the public health administration so as to utilize the funds gainfully.

**Equity**

To meet the objective of reducing various types of inequities and imbalances inter-regional; across the rural-urban divide; and between economic classes - the most cost-effective method would be to increase the sectoral outlay in the primary health sector. Such outlets afford access to a vast number of individuals, and also facilitate preventive and early stage curative initiative, which are cost effective. In recognition of this public health principle, NHP-2002 sets out on increased allocation of 55 percent of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targeted for 35 percent and 10 percent respectively. The Policy projects that the increased aggregate outlays for the primary health sector will be utilized for strengthening existing facilities and opening additional public health service outlets, consistent with the norms for such facilities.

**Delivery of National Public Health Programmes**

This policy envisages a key role for the Central Government in designing national programmes with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support monitoring and
evaluation at the national level by the Centre. However, to optimize the utilization of the public health infrastructure at the primary level, National Health Policy (NHP)-2002 envisages the gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, Malaria, HIV/AIDS, as also the RCH and Universal Immunization Programmes, would need to be continued till moderate levels of prevalence are reached. The integration of the programmes will bring about a desirable optimisation of outcomes through a convergence of all public health inputs. The Policy also envisages that programme implementation be effected through autonomous bodies at State and district levels. The interventions of State Health Departments may be limited to the overall monitoring of the achievement of programme targets and other technical aspects. The relative distancing of the programme implementation from the State Health Departments will give the project team greater operational flexibility. Also, the presence of State Government officials, social activists, private health professionals and MLAs/MPs on the management boards of the autonomous bodies will facilitate well-informed decision-making.

The Policy also highlights the need for developing the capacity within the State Public Health administration for scientific designing of public health projects, Suited to the local Situation.

The Policy envisages that apart from the exclusive staff in a vertical structure for the disease control programmes, all rural health
staff should be available for the entire gamut of public health activities at the decentralized level, irrespective of whether these activities relate to national programmes or other public health initiatives; It would be for the Head of the District Health administration to allocate the time of the rural health staff between the various programmes, depending on the local need. NHP-2002 recognizes that to implement such a change, not only would the public health administrators be required to change their mindset, but the rural health staff would need to be trained and reoriented.

The crafting of a National Health Policy is a rare occasion in Public affairs, indeed valuable, to allow our dreams to mingle with our understanding of ground realities. Based purely on the clinical facts defining the current status of the health sector, we would have arrived at a certain policy formulation; but, buoyed by our dreams, we have ventured slightly beyond that in the shape of NHP – 2002, which in fact, defines a vision for the future.

- **Medical Records and Documentation**

  For getting current data concerning patients general health and hospital activities needs much paper work and often considered boring and time consuming by some of the physicians and other doctors. But medical records are of vital importance clinically for immediate diagnosis and treatment and for future welfare of the patients. They play also a significant role in evaluation hospital services improving its
efficiency and in providing better patient care. In teaching institutes records serve as a resource for education and training and for post-graduation study. It also serve as a basis for further research. Value of complete and accurate records for legal purpose is also now well established. This all applies to even small hospitals as the primary objective for record keeping is to improve the care of the patient.

Records must present a comprehensive picture of patient’s illness with the physical findings and special reports such as X-ray and laboratory reports. All these records must be accurately written, properly filed easily accessible. It is clear that this important function also requires the special attention. The hospital organization must provide for the separate section under the control of qualified record librarian.

**Contents of Medical Records**

The medical record is clear, concise and accurate history of the patient's life and illness, written from the health and medical point of view. The story of the patient illness narrated by the patient, observations made by nurses and the Comments and the treatment given by doctors are recorded in the medical record. Medical records comprises three general section:-

(a) A general section covering administrative and personal data. The socio-economic record of the patient include-

- The name of the patients.
• Father’s or Husband’s name.
• Age
• Sex
• Religion
• Income
• Patient’s address and the address of nearest relative.
• Other administrative information.
• The data of admission
• The in-patient number
• The name of the nursing unit and the bed number.

This sheet is prepared in the central Admitting Office;

(b) A nurses section wherein are noted the observation of the trained nurses and the details of treatment administered. This part of the medical record consists of: graphic charts relating to Temperature, pulse rate, respiration, blood pressure and any other observations maintained, intake output chart and medicine administered;

(c) A medical section containing statements on the studies, observations, conclusions and activities of the attending doctors or of the intery or the resident working under him. The medical
section of the record consists of the entire medical history of the patient.

The hospital organization requires deliberate thinking on departmentation and it should have required departments/sections not only on medical side but also on management side to make it more professional.

**Classification**

The classification of records would depend upon the nature of organization. It would be useful to classify records into the following four-fold classification:

a. Vital Records
   - Protected and preserved for a long time

b. Important Records
   - Not currently in use but are of high value to retain

c. Useful Records
   - Currently used correspondence.

d. Transit Records
   - Useful for only a short period till the subject is alive or active.

**Mechanism of record management**

There are two basic instruments through which we create and maintain records i.e. form and files. In brief discussion about these two mechanisms is as under -
Filing: Filing is the process of classifying, arranging and storing records systematically so that these can be easily retrieved. The systematic arrangement for keeping of business correspondence and records so that these may be found and delivered quickly when needed for reference in future.

Filing is the placing of document and papers in acceptable containers according to some pre-determined arrangement so that any of these when required, may be located quickly and conveniently.

Filing Arrangement

The files can be arranged on any one or more of the following basis depending upon the need of the organization:

- Alphabetical order
- Numerical order
- Geographic order
- Chronological order
- Subject-wise

Many variations and innovations in these five general system of filing have been developed e.g. the use of colours, sound and special visual devices.

In the offices of the Government of India and State Government, filing system is bases on subject system. This system has many defects
lack of uniformity, lack of clear-cut demarcation of time consuming tracing process. The question of filing system was examined by the Administration Reforms commission and they recommended the functional filing system.

**File Indexing**

File Indexing is a key to locate the files. Index is a reference list used for locating a particular document in the filing equipment. The following types of indexing may be used for locating:

- Vertical card indexing
- Visible card indexing
- Visible book indexing
- Loose leaf book indexing

**Centralized and Decentralized Filing System**

Centralized filing system is one, where all the filing equipments are personnel are located in a single area of the office, accessible to all departments by messenger, controlled by a centralized plan or index of the filing. Decentralized filing system also called departmentalized filling system is one, where each organization makes its own arrangement for filling.

**Advantages**

Advantages of centralized filing are:

i) It ensures uniformity and standardization of the filing equipment
and procedure which can help in easy and quick location of records.

ii) It eliminates the need of duplication and distribution to all concerned sections. It encourages completeness of related documents.

iii) It enhances economy of time for both file users and file personnel because there is only one place to send material to be filed, and one place to find it.

iv) Control is exercised more effectively since one person or group alone is responsible, which minimizes oversights and loss of valuable records.

v) It promotes economy of filing equipment and floor space.

To be most effective a compromise has to be struck between centralized and decentralized filing systems. Decentralized filing should be kept to a minimum.

**Advantages of Records Keeping**

The records help the management in the following ways:

i) **Help in Sound Decision-making**: Effective decision-making depends to a great extent upon the adequate information provided by the records and availability of these records in time.

ii) **Effective Channel of Internal Control**: Records are very important to ensure internal control. Records can help in
minimizing chance of error and prevent occurrence of hand and corruption.

iii) **Facilitate Evaluation of organisational Performance**: The records can help in evaluating the performance of an organization during definite intervals of time and different periods. Besides, records can help in comparing the performance of organization in the same line.

iv) **Promotes Efficiency of Operations**: The effective operations of an organization depend to a great extent upon the speed and accuracy of the records. Records keep the wheels of the organization moving fast.

v) **Fulfils statutory Requirement**: Records are also kept in compliance with the provisions of different statutes. Besides, records are needed in the event of litigations, disputes or claims.

vi) **Futuristic Approach**: Analysis of records help in ascertaining future trends which can help in better policy-making and planning.

The fundamental reason for promoting maintenance of an adequate medical record is its utility to good patient care, to the doctor, to the hospital and towards medical education and research. Besides, the legal requirements of the hospital, medical records are also to be completed.
Use of Hospital Statistics for Management

The Medical Records Department in a hospital is mainly responsible for the collection as well as analysis of the data to ensure utilization of the hospital for patient care. Such data has immense value for the day-to-day management of the hospitals as well as future planning of the hospital services. Some of the important information which is used by the hospital management to enhance the hospital functioning are as under:

i) Death Rate: Hospital deaths include deaths of patients admitted to the hospital. Deaths are generally classified into two categories, i.e. the Gross Deaths and the Net Deaths. Gross Deaths include at the deaths of admitted patients while Net Deaths exclude the patients dying within 48 hours of admission. Net Deaths in a hospital is a reflection of the working of the hospital. Net deaths rate is calculated as follows.

\[
\frac{\text{Number of net deaths during a period of time}}{\text{Number of total discharges during that period of time}} \times 100
\]

In an average net death rates range between 4 to 6 percent. Any gross variations from the normally expected net death rate indicates an abnormal phenomenon which should be analysed by the hospital management. Such deviation can either be due to nature causes or due to failure on the part of one of the service area of the hospital in the case of later event correctives need be applied and death rate brought
back to the normal expected range.

The use of net death rates for enhancing the efficiency of the hospital services is not only limited to the overall net death rate of the hospital but also can be spitted up into death rates of various departments and units of the hospital. As such, the hospital management can keep a track of the performance of each and every unit/department of the hospital by keeping a track of their net death rates. This is being practised in most of the teaching hospitals but not in district hospitals.

ii) **Average Length of Stay**: The length of stay of patients is another important hospital indices. For purposes of calculations, the day of admission of the patient is always taken into consideration and the date/day of discharge is always ignored irrespective of the time of admission or the time of discharge. Through the process of discharge analysis, the average length of stay of patients discharged during a particular period of time is worked out not only for the whole hospital but also department-wise/ unit-wise. The aim of this information is to locate the unnecessary length of stay more patients can be admitted to the hospital and provided services. This information, therefore, is not only important from the economic point of view but is also important from the community services point of view. Average length of stay is calculated as follows:
Total length of stay of discharged patients during a period of time

\[
\frac{\text{Total discharges during that period of time}}{x 100}
\]

iii) **Bed Turnover Rate**: Bed Turnover Rate indicates the number of patients who have been given services per bed per year. It is calculated as follows:

\[
\frac{\text{Total Number of discharged during a year}}{\text{Total number of authorised beds}} \times 100
\]

Bed Turnover Rate is determined by the Average Length of Stay as well as the time interval between one discharge and successive admissions. This time interval is known as T-interval. Also, Bed Turnover Rate as well as T-interval are important indicators of the planning utilisation of hospital resources.

iv) **Bed Occupancy Rate**: Bed Occupancy Rate gives the relationship between the availability of facilities and their utilisation. Optimum bed occupancy is treated to be between 85-90 per cent. An occupancy of over 90 per cent means stress is on one or another area of the hospital. When the bed occupancy rate is 100 or more than 100 per cent, it is a case of dilution of hospital facilities and lowering of efficiency. Bed Occupancy Rate can be worked out for the whole hospital as well as for each discipline/unit of the hospital, as under:

\[
\frac{\text{Average daily census during a period of time}}{\text{Total number of authorised beds}} \times 100 = \text{Bed Occupancy Rate}
\]
• Ward Planning And Management

A ward is the heart of a hospital organization where the patients are kept. The first and foremost objective of hospitals is to care for the sick and injured and this task is being carried out in wards. Patients pass most of their time in the wards during their stay in the hospitals.

If the ward management is good, the patients are under good care and even the hospital personnel working in wards are happy and satisfied. The staff with job satisfaction always grow further in their profession and can get good clinical experience. On other hand, the absence of proper ward management will disturb the picture and bring inefficiency in hospital administration. Ward planning and management also need some education and training in management science for the persons concerned.

Ward management beings with ward planning. The ward must be made fully equipped with adequate physical facilities for the patients as well as for the ward staff. The nursing unit of the ward should be so designed that it can operate at the minimum cost and can also achieve at the same time the functional goals of the ward unit.

The size of the unit depends on some factors. It is quite natural that in the wards where critical types of patients are kept, the intensity of work remains high - like recovery room, I.C.U, ICCD, Burns ward etc. should be of smaller size while a chronic disease wards can have more space.
The ward management is having some functional goals which are as under:

i) To provide highest possible quality of medical care to the patients.

ii) To provide the most desirable patient environment.

iii) To provide the highest degree of job satisfaction for the nursing and medical staff and

iv) To provide the facilities to meet the needs of visitors and attendants.

The person in-charge of ward is known as ward-in-charge, or sister-in-charge. He/ She is responsible for managing the ward.

His/Her major functions are:

i) Good nursing care to the patient,

ii) Carrying out the instructions about medical care by the doctors,

iii) Supervise, guide and control the staff under her/him,

iv) Proper orientation for the new staff,

v) Evaluation of the ward staff on a regular basis through systematic methods, and

vi) Proper management of the ward.

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• **Medicine And Inventory Control**

Medicine and inventory control play a significant role in the hospital as they are directly related to patient's recovery from disease. Therefore, there must be used with due care, skill, knowledge and need. The medicine can be dangerous if not administered properly wasting of drugs also results in wastage of scarce resources of the hospital.

Apart from medicines a hospital also needs hundred of other things such as bandages, cotton, injection, syringes, needles, routine and specialized equipments for surgical and medical sections, furniture cots for patients, linen, slippers etc. Material manager has to look after all these things to help a smooth and uninterrupted flow of medical services to the patients.

Cost of inventories includes two major kinds of costs:

i) **Ordering Cost:** Every time when materials are acquired, certain costs of ordering are incurred such as getting quotations, preparing and placing a purchase order which includes clerical time, stationary, postage, transportation, handling, inspecting accounting, advertisement, salaries of personnel etc. the major components of ordering cost are salaries. To control the ordering cost, the number of men dealing with purchasing should be kept to the minimum.

If purchases are made in large quantities, the number of orders will be smaller and direct cost of inventories will be lower.
ii) **Carrying Costs:** All the cost incurred to maintain inventories are termed as carrying costs. They are also known as holding costs. The cost is usually expressed as a percentage of average investment in inventory. The Chief components of carrying costs are cost of capital invested in inventory, cost of storage due to the rent, taxes, insurance, depreciation costs, salaries to stores personnel, obsolescence, loss due to pilferage and breakage cost etc. The higher inventories, greater are these costs.

**Selective Inventory Control: The ABC System**

The hospitals carry inventories of thousands of items of manufacturing companies. It is neither possible nor necessary to exercise an equal amount of control on all the items. Many items are such low cost high volume items that expenses incurred on their close control may not be worth the saving resulting from it. On the other hand, there are items, which, though few in number, account for a large proportion of total inventory expenditure during a year it is not unusual to find that 20 percent of inventory items are responsible for 80 percent of its total inventory outlay. It is essential to use some system of classification of inventories which will enable management to decide upon the degree of control needed for various items.

ABC analysis separates inventories into A, B and C items. In order to make such an analysis, the list of all the stored items and their annual consumption in value is tabulated on the basis of the latest
available records. Each individual item and its annual consumption value is listed separately and then this list is rearranged in a descending order, beginning with the items of highest value and ending with the items of lowest value. When such an analysis is made, it is usually seen, that the first 10 percent of the items (A) approximately account for 70-80 percent of the value.

These type of inventories are the 'very few' and they involve high cost or small number and therefore should be controlled through scientific techniques of order quantity and re-order time.

Next 20 percent of item (B) 20 - 25 percent, B - class inventory items need relatively less close control. Their order quantity and re-order points may be determined on the basis of past trends in their usage. And the last 70 percent of items (C) only 5 - 10 percentage of the value. C class do not need close control. Orders for procurement may be placed when inventories in hand touch a low point.

ABC analysis of inventories permits their selective control. The analysis can be used as a guide for economizing purchases and controlling stores by having concentrated attention on the inventory control of A & B items.

3. **PUBLIC RELATIONS**

The importance of hospital public relation is well recognized. The most productive means the hospital has for creating and
maintaining good community relations are to render high quality of professional service and to establish kindly, sympathetic and understanding relationship with its patients, their relatives and their friends. Attaining both of these depend upon the aptitudes the competence and the spirit of every employee. Individually and collectively they mould the image and opinion of the hospital in the community. No group within the hospital is in a more favourable position to create good public relation than is the personnel of nursing department. It is the people for whom the hospital exists. It is they who make or break its image and reputation.

The study of doctor-patient relationship is of paramount importance, in the context of good patient care. It is to be realised that in this set-up both the participants are under a degree of stress. The doctor has to use his professional knowledge and skill, observing a degree of discipline and ethics to improve the patient's lot, who in turn looks upon him as a man of knowledge and science and who is pictured as kind, friendly, thoughtful and warm person, committed to do everything possible for patient's welfare. In this task he may be constrained by his ability time, communication, money, attitude of the referral hospital, hospital systems, hospital environment, etc.

In India, medical attention is claimed as a Fundamental Right and in turn a good deal of sympathy and human approach is shown in most of the clinics/ hospital (unlike in advanced countries like U.S.A., where monetary considerations rule supreme). It would be desirable to keep
the Doctor free from hunger, wants, exploitation and extraneous stresses, if the health care delivery is to be saved from complete commercialization. This entails giving him the conditions of confidence and comfort, so that he is neither affected by ego, nor enters into unhealthy competition to muster more and more money.

The conformation of a doctor and patient can be turned into a positive, congenial and curative relationship, with mutual support and co-operation. Patients do not always find it easy to reveal their worst anxieties or betray their real notions without encouragement and certainly not outside the framework of relationship based on mutual confidence and respect. Understanding the patients symptoms will require a peep into in his work environment, his relation with the employer and the associates at work, his sexual life, his social inter-relations and his friends.

It is the doctor-Patient relationship where the lay and professional perspectives and priorities most intimately meet accommodate each other and clash. Besides patients, doctors too very widely in their responses to illness situations. However, the doctor being member of a particular professional group, his actions are defined and confined by the law, ethics, time, space, inter-professional relations and organization of medical practice. Any contact between a patient and his doctor is usually a result of conscious choice on the part of the patient. Such a contact on the part of the patient may represent a desire as much for emotional support as for physical diagnosis or medication.
The patient's assessment of the professional's performance will be based upon his view of such things as the doctor's interest in him, the amount of information given to him, the willingness of the doctor to show concern, to take an interest, and his commitment to the welfare of the patient.

**The Government Doctor**

In our setup, most of the hospitals, dispensaries and the so called health centre are managed and financed by the central Government/State Government/Municipalities, etc. The salary of the staff, including that of the doctors is paid from the public funds. The patients have generally not to pay any fee to get consultation and other service.

i) **Impersonal Attitude**: Since it is not a fee for service situation, the doctors and others tend to be impersonal to the extent of being apathetic. The human beings in distress are treated more like subjects or even objects. With the result, the ailing citizens tend to get a feeling of non attendance, neglect and indifference, even if the treatment administered is timely, correct and adequate. Though, it is the citizen, who is neglected the most. He is not given any information. No one treats him as a person, since his social, personal and emotional needs are overlooked.

ii) **Indifference to job**: The Government doctor often refuses to develop any relationship with the OPD/Ward patients and tends to just mark his time. Some of them attend to only VIPs, who can
bestow favours in one way or the other, others do it for consideration. Some of them report only on the day of 'visit of the boss' other tend to limit it to the salary day. Many of them continue to run their business outside, even during the stipulated hours of the hospitals. A minority of them who work earnestly and with devotion, are called worldly unwise, eccentric or even foolish.

In this process, the patient care is wholly or partially sacrificed. When the reluctance to even look after the seriously ill is visible, where is the scope for preventive health, community education or to look into the promotions or rehabilitation aspects?

iii) Private doctors: Private doctors, who work to earn their livelihood (some of them to amass wealth on a commercial scale) have always been looked upon as step-sons (or daughters) by the Government or the doctors working in Government hospitals. While the Government has not taken any steps, may not, even given a thought to treat the large number of practising doctors as a vast resource (for the curative and preventive health of the community) the hospital colleagues view them somebody who are foreigners, inferior, rival and even cheats-who are engaged in minting money hook or crook.

Little do they realize that it is the practising doctor, who can undertake to provide the care medical and health care. Since their thriving depends upon the fee, directly collected from the members of the community, they have to build and maintain their reputation, which can rest on result-oriented service and not on cheating or misleading anyone.
If a practising doctor visits a hospital to help one of his patients in distress, who was taking treatment from him earlier, the practitioner is shown scant consideration, due to the in-built prejudices in the Government doctor's mind and the usual dilatory habits. Why?

iv) Confrontation: Where is the point of confrontation among these members of continuing health care team—both claim to help the ailing members of the community, both are paid in their own ways. It is not a mere clash of egos. There is a fault in our planning and training.

If the Government conceives them and treats as such, as the equal members of a continuing health care team, the problems would tend to minimise.

As a patient is referred or brought by a practicing doctor to a hospital colleague, it is not the duty of the latter to criticise the former—since it would not solve any problem. It is the duty of the hospital doctor to give the advice or treatment for the problem—for which the practicing doctor needed help. After doing the needful, the patient must be sent back to the referring doctor. Such a patient is obviously not an encroachment on the hospital, he is even more privileged to seek advice—since it is this patient, who needs the hospital attention most, as compared to another, who has come directly, and who may be suffering from a trivial ailment, which
may be treated easily elsewhere, say a small dispensary/clinic.

v) Patient is a Person: In any case, if a human being falls ill, he does not cease to be a person and hence he has to be treated keeping in view this fact. The hospital doctor or any other staff member cannot arrogate to himself to maltreat anyone of these unfortunate persons who happened to seek help and support form the hospital. Hospital is a public institution, which thrives on public funds and which is designed to serve the public, and the hospital staff is there to be subservient to the public.

If the practicing doctors undertake to provide all the front line medical and health care and the hospitals are used only for referred cases and the two components of health team work in unison, the coverage of population and the quality of health care will improve.

The emotional experience evoked (in the doctor) by the attitude and bearing of the patient. This experience is generally excluded while making a diagnosis. It is proper to some extent that this exclusion of feelings should be encouraged. It would be improper for the surgeon to be prevented from performing his technically essential but emotionally brutal function by the intrusion of his feelings during an operation. All doctors spend much of their time in a physical environment of deformity, pus and excreta and an emotional environment of pain, unhappiness and anxiety.

Of all the emotions that can be evoked in the doctor the one
least likely to be reported to the patient is depression. A depressed person does not express himself readily, but easily produces a feeling of depression in the people with whom he is in contact. If depression is not talked about, it is because this is integral to the nature of the emotion. A feeling which may be almost as difficult to talk about is sexuality, but this for fear it might not be controlled.

**Hospital visitor**

Hospital care often lags behind in the body of knowledge, advising sensitivity to the emotional needs of the hospitalized person, as also the attendants looking after him, his relations, children and courtesy-callers. Whereas one set of visitors comes and goes after leaving behind their 'get well soon' wishes, the other set has to keep hanging around the hospitals, to look for the patient.

The contact of the visitors and hospital-staff is at several points and starts right from the moment it is decided to seek hospital advice or admission. Generally, the first contact is with the enquiry/reception. This, if well-managed can help a lot to mitigate the subsequent sufferings of attendants and patients and can facilitate a great deal, the dispensing of medical care and the associated services, e.g., registration. OPD service, fee deposit, laboratory services and admission if required. Generally, the failures of hospital administration and its staff start from here and get accentuated as the patient proceeds further in various queues. More often the attitude of the reception staff
is impersonal, indifferent, inadequate, curt to impolite. The visitor to this counter is more often dealt away by putting off, rather than by offering him any tangible help. The sanie culture is perpetuated further, as he moves to get his card made, approaches the lift or awaits in the OPD at the mercy of the peon or a self-styled social worker.

In the OPD, where he is waiting anxiously to get attention of one of the doctors or a doctors or a doctor of his choice, he is pushed around, as if in a herd of cattle. His turn to see the doctor becomes a 'mirage', with politicians, VIPs, bureaucrats, hospital staff and others who matter not showing only respect for the queue, or the human beings in distress, huddled there.

The waiting in the congested and polluted environment, involving standing for hours, uncertainty of the 'turn' for the patient, with hospital noises, cries, smells and infections all round, prove to be a real test of nerves and physique, for the attendants.

Getting a hospital bed/room is the real measure of one's tactfulness, resourcefulness and manipulation. After passing through the rigmarole of formalities, the serious patient with his worried attendant arrive in the ward, here the hurried nurses receive him with a shower of “get out attendants, do not crowd here, allow us to work for God’s sake”- without enquiring as to why the hopeful people are roaming about.

When confronted with the job of getting some laboratory
investigations done, the patient’s relatives face another volley of hostilities. The sweepers and ward attendants are now here to be found and their work is allotted to the attendants of the patient, out of expediency, encapsulated in ‘patient’s interest’. After depositing the requisite fee for the tests, the relatives wander in search of the laboratories and its ingenious workers. When they turn up in the evening to discuss the report, the replies usually are ‘the blood was clotted - send it again’, ‘culture sterile’ or ‘shows growth of no significance’.

4. INTERNAL INFORMATION SYSTEM FOR MANAGEMENT CONTROL

The significance of information for administration can be compared to what Napoleon said about the army: “an army marches on its stomach,” - any administration marches on information. As the universe is saturated with information, health administration must select pertinent information for their programmes otherwise it is difficult to make any rational policy or decision. This technique is tailored to provide such information to the decision-makers which is most relevant, accurate, complete, concise, timely, economic, reliable and efficient. A good information system provides data for monitoring and evaluating the programmes and gives the requisite feedback to the administrators and planners at all levels.

The development of a suitable technique for a health information system would improve the capacity of health administrators to make
appropriate policy decisions. The information system may not serve the purpose if the health administrators are not committed to use the information constructively. The health administrators should use the available information sensibly and logically rather than construct complex information system which may not be used.

**ABC Analysis**

It is a technique which would enable a busy executive to chase those activities ardently which would quicken the wheels of administrative machinery. By arranging his work into an order of priorities, he can decide on which items to concentrate first, which others to deal later, and yet which others to delegate to his assistants. When done more systematically and in quantitative terms, this system of building up priorities of work is called the ABC Analysis. ABC Analysis can be of great use in dealing with materials management in hospitals. Forty to sixty per cent of the total expenditure of an organization is generally spent on materials. The other form of ABC Analysis is VED, i.e., arranging the activities in the orders of Vital, Essential and Desirable.

**Network Analysis (PERT/CPM)**

Both the Critical Path Method (CPM) and Programme Evaluation and Review Technique (PERT) emphasize efficient performance and temporal dimensions of a project. In the simplest form of PERT, a project is viewed as a total system and consists of setting up of
schedule of dates for various stages and exercise of management control, mainly through project status reports, on its progress. The CPM is basically a technique to reduce the time required to implement a project. By breaking the project into activities that must be undertaken for its implementation and by determining their time sequence, it is possible to isolate the most critical activities in the project and to compute the critical path schedule for their implementation. Network planning provides the basis for both CPM and PERT.

Moder and Philips enlist the following key advantages of using PERT.

i) It encourages logical discipline in planning, scheduling and control of projects.

ii) It encourages more long-range and detailed project planning.

iii) It provides a standard method of documenting and communicating Project Plans, Schedules and Time and Cost Performance.

iv) It identifies the most critical elements in the Plan, thus focusing management attention on the 10-20 per cent of the project that is most constraining on the schedule.

v) It illustrates the effects of technical and procedural changes on overall schedules.
Cost-Benefit Analysis

Cost-Benefit Analysis is an aid to systematic thought and helps the planners to decide as to what should be done - on the relative merits of different programmes. How far, for example, should resources be devoted to health education or maternal and child health services or immunization against particular disease? Any given budget for health may be distributed between programmes by including, first, those with the highest ratio of benefits to cost, then those with the next larger and so on, until the budget is fully allocated. The limitation of this method in the field of health administration is that it is difficult to express the benefits in monetary terms. We must encounter this limitation by making our tools of research methodology perfect.

Cost-Effective Analysis

Cost effectiveness methods are those that search for the least costly way of achieving a defined result. Cost effectiveness analysis are easier to make as the aim is clear. It helps the health administrator in managing his health resources at the local level. The problem is to find the way of achieving the objective at lowest cost, e.g., to find effective ways of treating patients without sending them to hospital. Linear Programming can help in this direction.

For better management every organization requires adequate, reliable and updated information. Without information decision making cannot be appropriate and effective.
“Management Information System” is now common in the science of management. It comprised three words - management, information and system. Each of these may be considered separately in order to arrive at what constitutes their combination.

(i) ‘Management’ is concerned with its functions like planning, organizing, directing, motivating, coordinating and controlling at every level of management. All these functions involve decision-making.

(ii) ‘Information’ is the basis for making decisions. Data in the form of facts and figures come from different sources. All information may not be relevant or useful. Only those data which can be retrieved, processed and utilized for planning, controlling and other operations can be termed as information.

(iii) ‘System’ refers to a set of elements or parts which are connected and interrelated for a common purpose. In organization, there are many departments, sections and sub-sections which are connected with one another.

Management information system may be defined as a structured and interlocking complex of procedures designed to collect, sort-out, process and store accurate information on all kinds of relevant matters and make it available without any loss of time to management as a regular support to problem solving and decision-making and the efficient performance of planning and other important functions.
Information is need for different categories of personnel are different and their purposes of getting information and areas and level of utilization also differ. For example, doctors a clinician requires all information about diagnostic and other patient data - complete and accurate - to be updated instantaneously and to be cumulative for the objective of proper patient cure on diagnostic data and examination of patient. This data can be used by senior and junior doctor and sometimes even by the nursing staff. It implies that at all levels these data of the public hospitals the duties of doctors change after specific period of time. In selected hospitals for the study, medical officers generally are being given morning, day, evening and night duties. For being able to perform these duties with full co-ordination adequate and timely information is required. This information must reach systematically among the medical officers who change their duties among themselves.

The administrator manager needs information about patient data on the basis of clinical and about work-loads on different departments, etc. to estimate loads of units, take decision for the future, develop plans for growth and expansion, etc. This information is collected from different levels and utilized for the whole organization. The administrator may divide hospital organization into several sub-systems for which concerned information is required for decision-making.

• **The Financial Sub-system:** Information of all concerned matters are
needed for planning, subsequent budgets and control. During the
execution of budget continuous flow of information is essential for
the purpose of control, i.e. to know whether: everything is going on
according to plans.

- **The Administrative Sub-system:** Various kind of information is
necessary for the hospital staff for their payroll, work distribution,
promotion, transfer, etc. Information must flow continuously in
regard to the inventory of drugs, linen, other supplies of important
materials, blood, etc.

- **The Consumer Sub-system:** The consumer in hospital organization
is the patient. The data of patients, both-outdoor and indoor, about
different diseases and their analysis, region or their origin, demand
for some new services, etc. is essential.

- **The Service Sub-system:** The information about scheduling of
operations' list, admission about scheduling of operations' list,
admission and discharge of patients, their diet and linen and other
requirements' planning plays an important role in hospital
organization. Moreover, information about the existing equipments
and instruments and their utilization is also essential.

Thus, information generates continuously at every level of
activity in hospital organization. All information have no permanent
value. But all kinds of information which is essential for appropriate
decision-making at any level of organizational hierarchy for any
category of personnel, must always be available in proper form at right
time to the concerned person. Hence, there must be some organized arrangement to collect, process, analyse, interpret and preserve the information.

5. **CRITICAL REVIEW**

For a sound management system in a government hospital it is essential that its organisation structure should be sound and fool proof and feasible also. Policy formulation and its implementation use to be backbone of any organisation and the same is in case of hospitals.

Policy formulation and its implementation can be made effective with the help of proper documentation and up keep of medical records proper ward planning and its management gives a hospital's goodwill. Availability of medicine and other facilities depends on a good inventory control system. A good inventory control system is dependent on internal information system in the organisation. Public relation department works as a bridge among a hospital management, patient and their attendants and also anybody who comes in the touch with the hospital.