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Review Article

Hospital Management in India

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Abstract

After India attained freedom, there was rapid industrialization in the country; but at the same time there was continuous growth of population which caused a number of medical and health problems. Special efforts were therefore made to solve those health problems and various committees mentioned below were set up from time to time. In 1943, a committee was set up under the chairmanship of Sir Joseph Bhore to work out an integrated system of health services in Inida. In 1960, the Mudaliar Committee was set up to examine all aspects of the existing school health programme in the country, e.g. prevention of diseases, medical care and follow up services, nutrition, and health education. This was headed by Smt. Renuka Ray. In 1963, a special committee was set up, headed by Dr. M.S. Chadda, to chalk out a National Malaria Eradication Programme.

In 1965, a committee to reorganize Family Planning Administration was appointed under the chairmanship of Dr. A.K. Mukherjee. In 1968, the government of India appointed the Jain Committee to undertake a study of the working of different classes of hospitals in the country with a view to improving the standard of medical care and developing sound guidelines for the future expansion of hospital services. In 1973, the Kartar Singh Committee on the multi-purpose worker under the Health and Family Planning Programme was appointed by the government.

Introduction

In 1974, the government of India appointed Jaisukhlal Hathi Committee to go into the various factors of the drug industry in India with a view to promoting the growth of the drug industry. In 1975, the Srivastava Committee was set up to report on medical education and manpower requirement. In 1977, a committee to report on strengthening of the accidents and emergency services in hospitals was set up under the chairmanship of Dr. S.S. Sidhu by the Ministry of Health and Family Welfare. In 1979, the Bajaj Committee was set up by the Government of India to lay down the guidelines for staff, equipment, space, etc. for different sizes of hospitals. In

1981, the government of India appointed a committee to review the status of medical education in India. This committee was headed by Dr. Shanti Lai J. Mehta. In 1986, the Ministry of Health and Family Welfare set up an Expert Review Committee called the Bajaj Committee for health manpower planning and development with major emphasis on the creation of additional facilities for vocational training.

The concept in the field of hospital is fast changing. The evolution of hospitals took place in different periods can be discussed here. It is broadly divided into four periods.

Trusteeship period

Most of the hospitals were run and managed by trustees. The advances in technology were minimal during that period. This period lasted till 1920. The doctors and nurses were not working for money, the approach was only humanitarian. The objectives of the hospital remained to provide comfort to the patient.

Physician period

It was physicians dominated period. The hospitals were being utilized for medical practice. The laboratory medicine developed during the period 1940 to 1950. The political and economic environment started influencing the hospitals.

Administrative and team periods

The hospital practice became a team approach. The advances in technology became more rapid. The use of computers and application of computers in patient's care and management of hospitals changed the scenario. People started thinking about professionally managing the hospital.

Growth of corporate sector

With liberalization policy of the governments all over the world lead to globalization. The rapid advancement in the field of information technology, with fast and safe air travel all over the world lead to the concepts of medical tourism. The concept of corporatization of the hospital. The hospital concept has changed from service approach to the profit making approach. The doctors have started thinking on management principles and functions for productivity. Telemedicine is a new addition. The patients can be treated and monitored by remote devices. The governments all over the world have started thinking about easing the burden of financing the healthcare. The new emerging concept of contracting or 24 PPP is growing very fast. The financing of health services though insurance sector has become need of the hour. Allopathic hospital and hospital beds in rural and urban areas including community health centre (CHCs) have tremendously increased. The state-wise distribution of hospitals and hospital beds in respect of community health centre, rural hospital and urban hospital.

Hospital Management in India

In India, Administration and management is thousands of years old. Five thousand year ago. Lord Shri Krishna proved his decision making ability, cool approach to problems, public relation skills, intelligence and determination. Dedication and counseling skills as a 'Administrator and a Leader"^ the scientific management started in late 1950 in India, when Department of Management were established in Indian Universities. This followed the establishment of Indian Institute of Management (IIM) beginning in 1960. First time, in 1939 American College of Hospital Administration designed a code of ethics for hospitals.

Administration or management is a science and an art like medical sciences. Professional hospital and health care administrators have proven how hospitals can be managed effectively, economically and efficiently in targeted time period. After independence, India has a rich heritage of administration. Hospital administration opened up a hoard of career opportunities, never seen before. Indian health professionals were in demand not only in India but also in countries like the US, UK, Germany and Japan. About 90 per cent of the work which the medical administrators do in administration does not require medical knowledge and on the other hand, people with medical background have no training in hospital management. This results in misutilisation of the technical manpower and inefficiency in administration.

Today's organizations are facing their toughest competition in decades. Only patient centered organization will win, those who can deliver superior value to their target patients. The health care services, which were good yesterday, barely meet the requirement of today and will be inadequate tomorrow. In the age of technological revolution, customer needs are continuously increasing, customer expects a speedy response of their queries, and there is greater competition. which demands improvement in health services. Thus the need of quality service from the hospitals is necessary.

Based on geographic levels In India there is three- tier system of structure in health care. This consists of the primary health centre (PHC) community health centre (CHC) and the district hospital. These three levels roughly coincide with the three administrative levels of control, the Gram panchayat (GP). The PHC being population based may not coincide with every village level. However the other levels would coincide. The level of care provided at these three levels is known as primary, secondary and tertiary.

Primary health care centers

Primary health care centers constitute elementary medical and primary health care at the village level.

Purpose

The primary health center is the peripheral institution from which health services radiate to the rural community. It constitutes the embodiment of the new concept of integration of preventive and curative care. The centre is founded on principle that the maintenance of health is just as important as the treatment of disease and to secure both, all concerned must work as a team. It is the smallest agency which provides preventive and curative health services including family

planning in a integrated manner to the rural population. The idea of developing primary health centers for providing comprehensive health services in the rural areas of India was first presented in a concrete form by the Bhore committee in 1946. .

Coverage

Each primary health care centre is targeted to cover a population of approximately 25,000 and is charged with providing primitive, preventive, curative and rehabitative care. This implies offering a wide range of services such as health education, promotion of nutrition, basic sanitation, the provision of mother and child family welfare services, immunization, diseases control and appropriative treatment for illness and injury. The PHC hubs with 5 to 6 sub-centers covers 3-4 villages are operated by an auxiliary nurse midwife (ANM). These facilities are as a part of the three tier health care system. These PHCs act as referral centers to the community health centers (CHCs), with 30-bed hospitals and higher at the taluk and district levels.

Reasons for average performance

Primary health care services substantially affects the general health of a population, however many factors undermine the quantity and efficiency of primary health care services in developing countries. In India, there are many reasons for poor PHC performance. The reasons are Lack of political commitment, Inadequate allocation of financial resources to PHCs, stagnation of inter-sector strategies and community participation, bureaucratic approach to health care provision, lack of accountability and responsiveness to the general public and incongruence between funding and commitments. The current structure is extremely rigid, making it unable to respond effectively to local realities and needs; Political interference in the location of health facilities often results in an irrational distribution of PHCs and sub-centers. Government health departments have focused on implementing government norms, paying salaries, ensuring the minimum facilities rather than measuring health systems performance and health outcomes, community involvement of etc.

Secondary or District Level Health Care Centers Medical care provided by specialists at the Mandal (taluk), sub-divisional and community health centre level are secondary health care centers. The medical facility available here is called as community hospitals. The effect of the concept of regionalization of health care could be felt here. There should be enough staff and equipment here for the patient to receive secondary level treatment. If this centre or the hospital is well equipped and staff would take the load off the district hospital. At present due to insufficient staff and equipment, often it is seen that the patient goes from the PHC to the district hospital directly.

Territory Level Health Care Centers

Sophisticated care provided by super- specialists at medical colleges and hospitals (district head quarters) at territory level health care centers. The territory level services are provided at the district hospital, and concentrates on specialized services like sophisticated laboratory and investigative facilities. Better facilities for treatment exist here. More complicated and high-tech

operations and treatment of a higher order are offered. This is the apex of the pyramid of regional care as has been earlier started. Cases are referred from the primary health center at the village level to the community health center at the block and taluk level, from there; the more complicated cases are referred to the district hospital.

Based on ownership Hospitals can be classified as under based on ownership- government and private.

Government Hospitals

They can be those owned by central, state, or local administrative bodies.

• Central Government

All hospitals administered by government of India are run by the departments like railways, defense, mining, ESI, post and telegraphs, public sector under takings of Central Government.

• State Government

All hospitals administrated by state/ UT Government authority.

• Local Bodies

All hospitals administered by local bodies like, Municipal Corporations, Municipalities, Zillaparishads, Panchayats, etc.

Private hospitals

These include the service oriented hospitals run by trusts or religious bodies like Christian missionaries as well as commercial type individual or partnership concerns.

• Voluntary Organization

All hospitals run by a voluntary bodies, trusts, charitable societies, registered or recognized by the appropriate authority under Central or State laws, Missionary body and Co- operative Societies.

• Private Hospitals

All hospitals run by individuals or by private organizations.

Service orientation Health care service is the combination of tangible and intangible aspect with the intangible aspect dominating the intangible aspect. In fact it can be said to be completely intangible, in that, the services (consultancy) offered by the doctor are completely intangible. The tangible things could include the bed, the décor, etc.

Hospital is the organization that dreams up an idea of service offering (treatment), which will satisfy the customer's (patient's) expectations (of getting cured).

• Patient

The patient is the customer who seeks to get cured. He is the one who avails the service and pays for it.

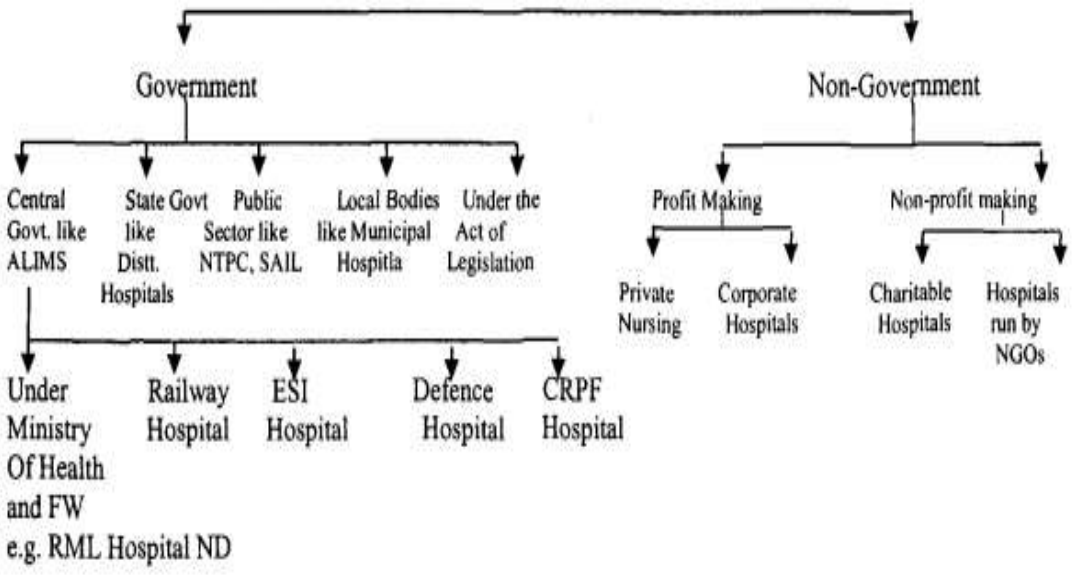
• Doctor

The activating organ of the hospital is the provider the doctor. He is the one who comes in direct contact with the patient. The reputation of the hospital is directly in the hands of the doctor.

1.3.4 Classification Of Hospitals

According to WHO definition of hospital, only very few hospitals will qualify to be called as hospital. There are a wide range of hospitals. Some hospitals are small, some are big, some imparting teaching and training facilities, some are owned by private bodies, some are specialty hospitals and so on. These hospitals can be categorized or classified in several manners. Some of the methods of classification of hospitals are given below:

Figure 1.2: Classification based on Sectors



According to ownership and control

The hospitals run by central or state governments, local bodies and public sector undertakings. The hospitals are purely service organizations and non-profit making hospitals. Examples are civil hospitals. b. Voluntary hospitals: These hospitals are registered under the Societies Act or Public Trust Act. They are run by trusts and non-commercial basis examples, charitable hospitals. c. Nursing homes: Generally owned and managed by individual doctors. These hospitals

generally do not admit cases of medico legal importance and the patient care services are usually provided in some of the specialties of medicine. Some of the nursing homes provide only maternity care. Some hospitals even provide tertiary care in some super specialties like cardiology, nephrology. Examples are Mayo medical centre, Nanjappa hospital, Usha nursing home, Vastalya nursing home etc. d. corporate hospitals: These hospitals are run on the basis of profit earning and are registered under Companies Act. Examples are Hinduja hospital, Apollo hospital etc.

According to directory of hospitals

General hospital

These hospitals usually provide medical care in more than one broad specialty and there is no strict departmentation.

Rural hospitals

The hospitals located in rural areas,

Specialty hospitals

Hospital providing medical care usually in one or more specialty like TB hospital, Eye hospital, Cancer hospital, Heart centre's, etc.

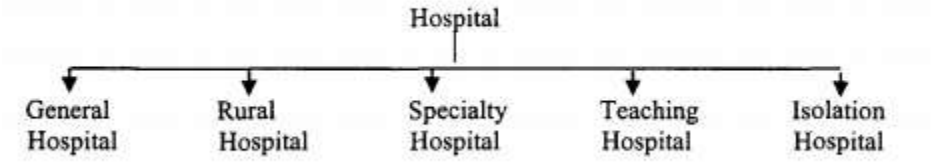
Teaching hospital

Usually the hospitals attached to medical college.

Isolation hospital

Hospitals providing patient care to communicable diseases.

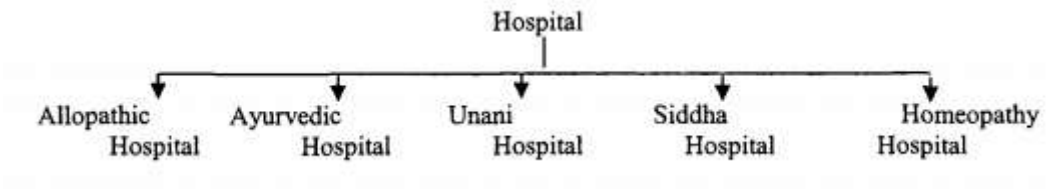
Chart 1.2: According to directory of hospital



According to systems of medicine

Various systems of medicines like Allopathy, Ayurvedic, Unani, Siddha, Homeopathy, have their own hospital.

1.3: According to system of medicine



According to size of hospital

The hospital can be classified as small, medium or large size depending upon the bed strength of the hospitals. Hospitals having more than 500 beds are usually called large hospitals. Hospitals having bed strength from 200 to 500 are called medium size hospitals and hospitals having less than 200 beds are small hospitals.

India became free in 1947 and there were 7400 hospitals and dispensaries in India. There were 19 medical colleges and 19 medical schools. It was felt by Government of India that with the rising population and projected growth rate it would not be possible to cope up with the health needs and demands of the community. Various committees were formed to suggest means and methods to reorganize the health care delivery system. Some of these important committees were Bhore Committee, Mudaliar Committee, Jain Committee, Siddhu Committee, Rao Committee, Srivastava Committee and Bajaj Committee. As per Health Information of India 2004, we have 229 medical colleges, 189 dental colleges, 209 Ayurvedic medical colleges, 36 Unani, 6 Siddha and 180 Homeopathic medical colleges. As on 1st Jan. 2000, Indian has 15,393 hospitals with 914543 total beds and 89 beds per lakh population. India has 3043 CHCs, 22842 PHCs and 137311 sub centres as on 31" March 2001^ Since independence lot of advancement has been made in health sector but still much remains to be done because still all these figures are far below the national target of at least 1 bed per 1000 population as recommended by Mudaliar Committee in 1961.

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