Education for Health Administration in India

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This article is based on a paper presented by the author, Vice-President of Trained Nurses' Association of India, at the First International Course on Education for Health Services Administration at Lisbon some time ago.

INDIA is one of the biggest democracies in the world with a population of over 700 million. This population is scattered in different States and about eighty per cent of people live in the countryside (rural area). Health of the population is but one of the basic needs and desires of a community irrespective of its urban or rural dwelling. There is in India, as elsewhere, an inevitable competition for resources between health and other social services. Health sector has a varied and wide relationship with other social sectors of the overall social system; which implies that what happens in other social sectors may support, negate or offset the preventive, promotive, rehabilitative and therapeutic intervention of the health sector.

The Constitution of India is federal in structure and Health is a State subject. The Constitution lays down that "the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as amongst its primary duties." To give effect to this directive, health has been given due priority. Though health is the primary duty of the States the federal government, however, guides, sponsors and supports major schemes for improving the health of the people. The Ministry of Health and Family Welfare coordinates the work of the State governments. There is a Central Council of Health which advises the Ministry on policies and planning in all aspects of health care and health maintenance.

Although health is a basic human right, in our social system a large proportion of population still do not have access to some reasonable level of health care in terms of both quantity and quality. Ever since Independence the Government of India and the State governments have been evolving various approaches for rural development but the social aspect of impact of development has mostly gone by default because health has not been an integral part of development plans.

Economic growth with social justice is one of the most important goals of the developing countries. Attainment of this objective calls for the adoption of modern technology to the processes of production and management. This requires in turn a reorganisation of their traditional institutional structures and reorientation of the attitudes of the people towards modernisation. As these developments are not spontaneous, India, being a developing country, has been adopting a planned approach to economic and social development within a federal democratic framework.

The crux of the problem in the health services is the physician and especially the extent to which the community employs him or her in a practitioner's role or managerial role. In the management of the complex web of health services it is essential that both types of physician must be present in varied ratios. In our developing society this ratio of practising physician to managerial physician is left to chance; thus, our health and health care institutions are left flouundering for they have no proper base. But it is only the physician who has been educated to choose with discrimination from that total information developed in the medical sciences, precisely those elements that are relevant to the problem of individual patient (practitioner) or a whole community (manager).

Our health institutions were developed to provide one type of service, i.e., curative and to one type of society, i.e., urban. These institutions are being transplanted without thoughtful adaptation to the very special needs of our society. We are enamoured by the modern concept of service demanding service complete health care, i.e., curative, preventive, promotive, and rehabilitative. But we do not have the system to organise such services effectively.

The preparation of the physician involves both education and training. By education is meant the transmission of a body of knowledge and principles to a person to the point that he or she is capable of unlimited self-education thereafter. Training is the repeated supervised performance of an act, so that it can be performed unsupervised with predictable and reasonable accuracy.

The greatest challenge of the times in the field of health is medical education or the education of the physician versus training of nurses as practitioners and managers. The preparation of physician can neither meet the role of practitioner nor of manager whereas University education of nurses can meet the requirements of both practitioners as well as managers.

The Government of India is seriously considering change in the policy of medical education and for this purpose a high powered committee has been set up to reshape the medical education to fit the modern society and its changing cultural pattern. This may also consider educating, as practitioner as well as

manager.

We find ourselves at a critical juncture in our development associated disciplines which are helping us to learn a great deal about portions of the subject of administration while others are adumbrating concepts of the totality of actions of which administration is a part. Hospital administrators are coming to understand that administration in the context of hospitals is neither exclusive business book keeping on the one hand nor deciding substantive medical issues on the other.

There is need to develop a corps of managerial functions of the physician or hospital health administrator which is the object of this paper. Because if we want to learn more quickly and effectively we must discipline our experience with creative education. Management tool and techniques are valuable to almost every individual and organisation. But they are not of themselves management. The information produced by these devices has to be examined, interpreted, assessed, e.g , work study does not lead automatically to higher productivity or improvements. Some one has to put the results of work study to work.

We often talk of Business Administration, Public Administration and Health Administration but there is no administration as such. We make generalisation difficult because of separate schools in universities. We organise in separate professional societies and we have developed separate bodies of literature which speak of one another infrequently. All the three had much in common (Business Administration, Public Administration and Health Administration) and there is need for synthesis depending on the knowledge and skill of the administrator. Because of an essential universality in the administrative process the knowledge and skills are transferable. This requires special preparation bec ise the hospital adiministrator "who has not had a medical or Nursing training is no doubt seriously handicapped, but not more seriously than the medical man who lacks executive ability and business and finance experience." Most physicians can be disqualified through the very nature of their work.

Health and hospital administration is nothing different than administration of any other social organisation. Health administration in any country, developped or developing, is faced with a broad spectrum of managerial problem and all have one basic problem common: How can one best improve the health status of the people ? This problem has become more pressing owing to changes in the needs and expectations of the people and development in health and other technologies and the urgent need to link health with other social, political and economic development in the country.

A broad analysis of the evolution of health services and development under various social, economic and political development plans will provide a clearer perspective of different dimensions of health status of the people and need for Health Adn istration.

Development Plans and Health

India adopted centralised planning system under the Five year Plans with the purpose of reaching the grass-roots level for overall development. With its 700 million population and scattered States a total of 5253 Community Blocks have been developed.

Facts on India

Area in sq. mts.	3287.8
Population	680 M.
Density	200 P. K. M.
No. of Districts	400
No. of Towns	3126
No. of Villages	575936
No. of C Blocks	5253

Each community block consists of a cluster of 20 to 25 villages serving an area of 400 to 500 kms. The focal point of delivery of health care in these community blocks are Primary Health Centres (PHC). Each PHC caters to the need of 80 to 100 thousand population through three Sub-centres, each Sub-centre serving a population of 25 to 30 thousand. The linkage to the district hospital is through the Sub-centre, PHC forming a three tier system.

It is believed that equitable health care system stimulates development through improving human productivity because an individual is a productive unit of the society. Moreover, a low productive capacity of the individuals will result in low per capita income and poverty which will yield to poor nutrition, illness and unhygienic conditions. Thus social investment and investment in health is investment in human capital and is mainly concerned with investment in human beings. It is necessary not only to provide opportunities to individuals for self development but also as a contribution to overall economic development. But these social and economic development, are reciprocal and complementary, but are subjected to political will and environment. Dr. M. G. Canadu, former Director-General of World Health Organisation, remarked :

> Amongst the objectives of development are health and productivity, they are reciprocal and complementary. Without health productivity can hardly flourish. On the other hand, productivity may increase means and opportunities for better health.*

During the first and second Five Year Plan periods emphasis had been on control of communicable diseases and provision of increased institutional facilities which served as a base for organising health services and making provision for training of infrastructure required for increased facilities.

TABLE 1

Hospitals/PHCs/Beds

	1960-61	*1971-72*	*1980*
1. No. of Hospitals and Dispensaries	12,000	14,438	17,501
2. No. of PHCs	2,800	5,195	5,499
3. No. of Sub-centres	—	32,218	49,323
4. No. of Hospital Beds	1,85,600	2,98,304	4,60,886
Beds 0.83 per 1,000 Population			

* *World Health*, March, 1969, p. 5.

In the Third Plan the approach was on integration of Public Health with maternal and child welfare, nutrition and health education, whereas in the Fourth Plan P.H.Cs were strengthened. It was first time that the objective of reducing the birth rate from 39 to 31 per thousand was laid down which is by now 33 per thousand.

TABLE 2

Birth and Death Rates

Period	*Crude Birth Rate*	*Crude Death Rate*
1901-1911	49.2	42.6
1911-1921	48.1	47.2
1921-1931	46.4	26.3
1931-1941	45.2	31.2
1941-1951	39.9	27.4
1951-1961	41.7	22.8
1961-1971	41.1	18.9
1980	33.0	15.0

Death rate has by now also fallen to 15 per thousand which is indicative of increased standard of living, and increasing span of life thus increasing the population in the older group for which special services and facilities will be desirable.

TABLE 3

Average Expectation of Life at Birth (Years)

Period	*Male*	*Female*
1901-1911	22.6	23.3
1911-1921	19.4	20.9
1921-1931	26.9	26.6
1931-1941	32.1	31.4
1941-1951	32.4	31.7
1951-1961	41.9	40.6
1961-1971	46.4	44.7
1980	52.6	51.6

Family Planning targets in the Fourth Plan were assigned to each PHC and Sub-Centre with incentives. Post-Partum F.P. Programme was introduced. Simultaneously came into being M.T.P. (Medical Termination of Pregnancy) Act which was designed to liberalise the provision to resort to abortion in cases where there was undeserved conception ;

Intensive Area District Programme with an extension approach as a pilot project was started. In this project efforts were made to involve the consumer as a participant in health care by associating with Panchayati Raj. Such project revealed that given encouragement, respect and skilled assistance to village leaders, they could assume responsibility for major aspects of health care and family planning in their own areas.

In the Fifth Plan a national strategy in health was planned and the various supporting services were strengthened as a provision for a minimum needs programme.

TABLE 4

Health Supportive Services

1. Nutrition

2. Environmental Improvement

2.1. Safe Drinking Water
2.2. Disposal of Waste and Severage
2.3. Housing and Settlement
2.4. Pollution Control
2.5. Healthy Work Environment

3. Health Education

The Sixth Five Year Plan (1978-83) evisaged a multisectoral integrated approach to improve health with the objective that health was a social unit and needed priority and should be made available to all. During this period Primary Health Care has been one of the basic national objectives after the Alma Ata declaration. The changes envisaged in accomplishing the objective of Primary Health Care plan a five-tier system instead of a three-tier system discussed earlier. In this approach to delivery of health care each PHC will have attached to it eight Sub-Centres instead of three each serving a population of eight to ten thousand each. PHCs have been upgraded and hospital beds have also been provided in upgraded PHCs, which serve as rural hospitals. This PHC is linked with the District hospital and Regional hospital which is a teaching hospital. The emphasis in this approach is on regional and referral systems. In the implementation of this five-tier approach with a referral system no major breakthrough is possible without the aid of a sophisticated information system (communication system) which through control would make possible the extremely difficult task of managing organised complexity for creative approach to crucial tasks ahead.

TABLE 5

Five-Tier System (Referral System)

1. The Village Neighbourhood level health services for a unit of 1,000 population;

2. Health services at the Sub-Centre level for a population of 5,000;

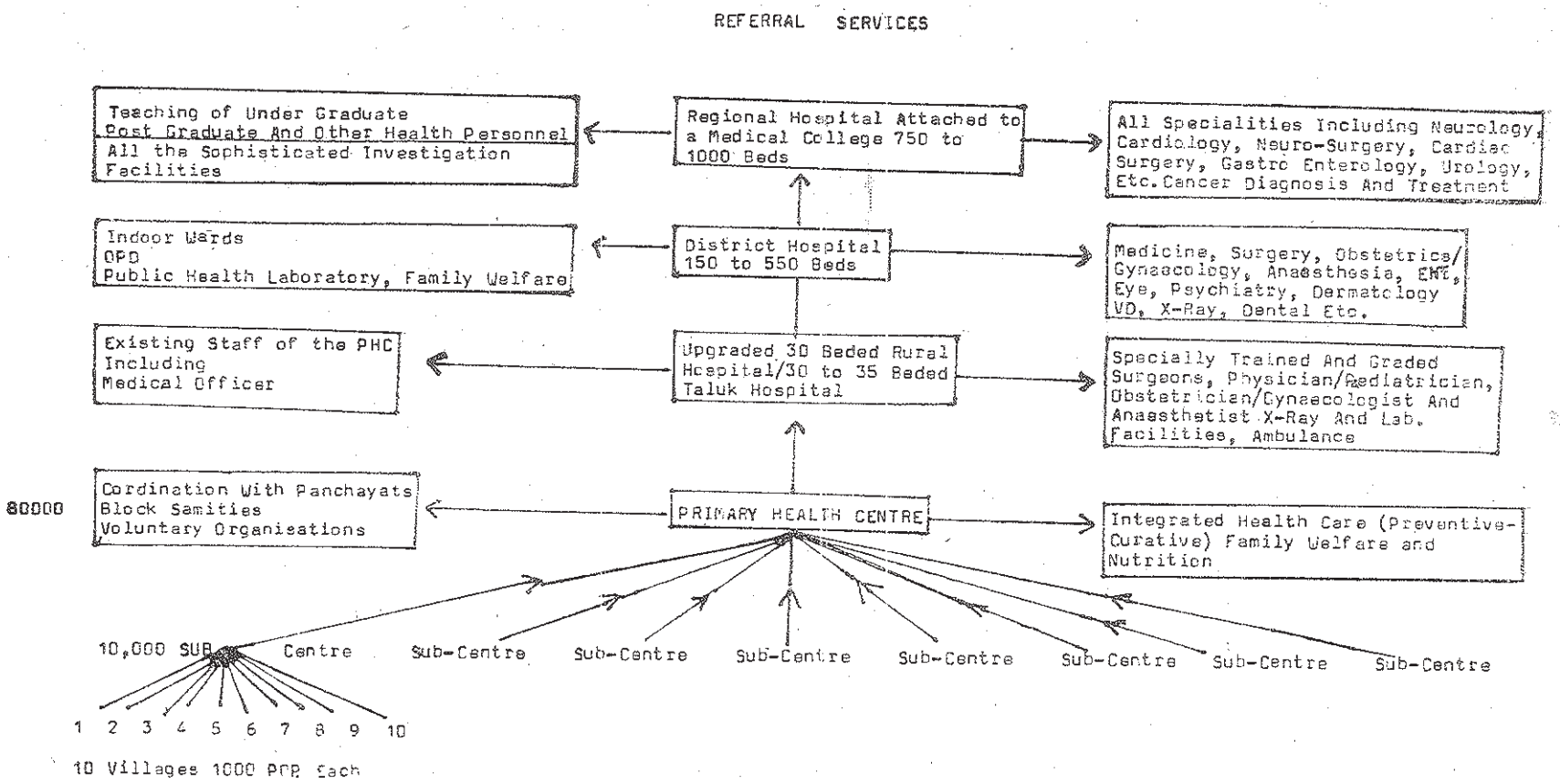
3. The Community Health Centre at the 10000 Population Level;

4. The District Health Centre for a population of 1000000;

5. The Specialist Centre for a population of 5,000,000;

6. Training institutions, special institutions for research and training and State and Central Health Administration;

In a study of the Indian Council of Medical Research and Indian Council of Social Science Research the alternative strategies suggested are on similar lines and support five-tier system.


REFERRAL SERVICES
Teaching of Under Graduate
Post Graduate And Other Health Personnel
All the Sophisticated Investigation Facilities
Regional Hospital Attached to a Medical College 750 to 1000 Beds
All Specialities Including Neurology, Cardiology, Neuro-Surgery, Cardiac Surgery, Gastro Enterology, Urology, Etc. Cancer Diagnosis And Treatment
Indoor Wards
OPD
Public Health Laboratory, Family Welfare
District Hospital 150 to 550 Beds
Medicine, Surgery, Obstetrics/ Gynaecology, Anaesthesia, ENT, Eye, Psychiatry, Dermatology VD, X-Ray, Dental Etc.
Existing Staff of the PHC Including Medical Officer
Upgraded 30 Beded Rural Hospital/30 to 35 Beded Taluk Hospital
Specially Trained And Graded Surgeons, Physician/Paediatrician, Obstetrician/Gynaecologist And Anaesthetist X-Ray And Lab. Facilities, Ambulance
80000
Cordination With Panchayats Block Samities Voluntary Organisations
PRIMARY HEALTH CENTRE
Integrated Health Care (Preventive-Curative) Family Welfare and Nutrition
10,000 SUB Centre
Sub-Centre
Sub-Centre
Sub-Centre
Sub-Centre
Sub-Centre
Sub-Centre
Sub-Centre
1 2 3 4 5 6 7 8 9 10
10 Villages 1000 POP Each

Whatever had been the approach to health the allocation of resources in the past had been inadequate but an effort had been made in the Sixth Plan (1978-83) to enhance these which still remained limited and showed a narrow commitment in contrast to loud promises made. It is now that the people's own consciousness about their health problem is generated through participation at the village level. This is a step in democratisation in health care system and is to come out of this conscience creating stage. We have to make decision makers more conscious of their performance in this respect.

During the Plan the initial success and achievements had been noteworthy and admirable. Inspite of the accomplishments the lessons of the last few decades have clearly brought home the severe limitations due to the traditional administrative system in handling complex managerial functions and responsibilities. If the future had not projected a diminishing role for development programmes, the present limitations need not have received much thought. Some of these have been highlighted in the Sixth Plan.

TABLE 6

Iniquitous Health Structure, Reasons For

1. A Borrowed Top Heavy Structure.
2. Concentration of Services to only Urban Sector.
3. Health industry only a drug-oriented and curative Industry.
4. Ignores traditional system of medicine.
5. Hospital as institutions are monolithic, isolated units.
6. Medical education is only disease-oriented.
7. Divorced of other sectors (social, economic, cultural and conditions of work)
8. Inadequate information and communication system.
9. Health care system organisation is viewed as devoid of peole.
10. Not need-based and lacks consumers' participation.
11. Absence of standards and uniformity of procedures.
12. Inadequate understanding of division of labour and emerging new infrastructure.
13. Absence of orientation, in-service and continuing education system.
14. Absence of classification of care and institution for LTC, STC.

Given the present expectations of more intensive developmental activity in the years to come, ameliorative prescription requires special consideration. Of crucial importance is a change in the attitude of the existing administrative system towards the management of the health programmes. Apart from such attitudinal change, the entire tradition bound administrative system which is a legacy of the colonial power since independence and involved in the development activity suould be restructured to perform those managerial functions which have vital implications for operational purposes.

Above all, the need is great for a well organised system of administrative machinary for total health care system and for planning of each programme so that physical phasing of these programmes into systems and sub-systems clearly matched in terms of its organisation and the availability of financial personnel and material inputs.

(To Be Concluded)