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Secondary level hospital roles

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The 30th World Health Assembly in 1977 decided that the main worldwide social goal should be the attainment of health for all by 2000. The WHO declaration of Alma Ata in 1978 adopted the strategy of primary health care (PHC) to achieve this. Health, education, nutrition, family planning, immunisation, and the prevention and control of locally endemic diseases are the more important components of PHC. As the scene of action under these components lies in the family and primary social groups, they can be conceived as the front line component of PHC.

In India most of these front line components are administered through the primary health centres. However hospital services do have a very useful place in the overall scheme of PHC and also have to play complementary roles for the implementation of its frontline component. WHO has advanced the following principles regarding the role of hospitals in PHC.

A health care system based on PHC cannot exist without a network of hospitals with responsibilities for supporting primary care and hospital care. Both are essential parts of a well integrated health care system.

An effective PHC system can only be achieved within the framework of a comprehensive district based health care system serving a defined population; and the district itself, must be a part of a regional and national health care system.

A survey of about 65 hospitals in and outside Delhi has revealed that a majority of the hospitals are already playing a role in areas like family welfare, immunisation, well-baby clinics, dental health and so on. Thus hospital services can be conceived as the supportive or infrastructural component of PHC. Hospitals have a vital role to play as referral centres and resource centres. Hospitals, as centres of medical professionalism in all positive meanings of the word, could make use of their power, for the health of the world around them.

Hospital size and location

The big urban hospitals which mop up a large proportion of the allocation for health are generally impersonal, unwieldy, unmanageable institutions which profess to give sophisticated health care at high costs and often fail to deliver even simple curative services. Their benefits are generally small, especially if one considers the vast investments which go into them.

A major reason for the failure of these high cost, low efficiency institutions is the penchant for size and the latest western sophistication which adds considerably to their mystique and reputation.

One of the major reasons for the inaccessibility of the existing hospital to the majority of our people is the problem of distance. Hospitals, whatever their size, receive the majority of their clientele only from an area which is within easy reach. It is not only the cost and difficulty of transport for the patient, but also the relatives who must accompany him. The impersonal atmosphere and culture of the staff of such a hospital is very alien to the poor villager who feels ill at ease. The lack of residential accommodation for the relatives poses a further problem. Little wonder that the majority of our people cannot utilise these hospitals even when in need.

Under the circumstances, if we are to make hospital referral facilities available to the majority of our people, especially in the rural areas, it is essential to have a hierarchy of hospitals of appropriate sizes commensurate with the needs of the population, as near the population as possible. A network of community hospitals, area hospitals and district hospitals will serve the cause just as well as small yet efficient general hospitals placed within the community itself.

The advantages of such a community, area or district hospital will be: physical proximity to the people; greater cultural acceptability; personal attention as a result of small size; facility for relations who can accompany and stay in the adjoining religious school and feed and take part in the nursing care, thus leading to a humane approach; avoidance of the inhuman, impersonal approach of the large hospital and a greater interplay of human inter-relationships not only between patients and staff, but also between the members of the staff themselves; and elimination of expensive administrative overheads.

One of the objectives of the Reorientation of Medical Education programme (ROME) introduced by the Government of India was "the development of effective referral linkages between PHCs, district hospitals and medical colleges". The seventh five-year plan document emphasised that the network of hospitals needs to be further strengthened gradually towards the objective of one hospital bed for every 1000 people. It aimed at rational distribution of hospital beds and prescribed that about 30 per cent of the beds should be available at the first referral level (that is the community health centre and sub-district hospitals) and about 40 per cent of the beds should be available at the district level.

Therefore, the seventh five year plan aimed at a very large network of secondary level hospitals accounting for 70 per cent of the total beds. This otherwise constitutes the small and intermediate level hospitals. As most of these hospitals do not have much teaching activity, they are commonly referred to as nonteaching hospitals. Table 1 shows the distribution of hospital beds in governmental medical institutions in Andhra Pradesh as on 1 April 1987.

It is clear from this that the teaching hospitals are already having a disproportionately larger share of beds. That means the hospital services are very much central-

Type of hospital	Beds as on 1 April 1987 number	Percentage of total beds
Teaching hospitals	12 190	42.0
District hospitals	4 108	14.1
Taluk hospitals	4 600	15.8
Other hospitals	2 939	10.1
Primary health centres	5 228	18.0
Total beds	29 065	100.00

Table 1.

ised in the teaching hospitals. As against the seventh plan norm of 70 per cent, the district and taluk hospitals including the other hospitals account for just 40 per cent of the total hospital beds. This indicates that the secondary level hospitals are the weakest link in the present system. It is quite natural that a lot of attention needs to be bestowed on secondary level hospitals.

The recent advances in medical technology have brought with them a crisis in health care planning even in developed countries. The key factor in the crisis is the cost. In recent years many countries have considered changing, or indeed have changed the method of financing their health services. The WHO workshop on hospital financing systems in 1984 at Kiel University, Germany, examined the implications of different financing systems.

The workshop identified two broad categories of financing systems, that is the fee-for-service or reimbursement system and the budget or population based system. The fee for service system is characterised by high national cost of health care and over-provision. The budget based system is usually characterised by low national cost of health care and under-provision.

It emerged that in the context of any national economy, the relative scarcity of resources has a more significant impact than how in fact those resources are generated. Nevertheless, it was clearly identified that the additional resources, generated under a fee-for-service financing system tended to result in a higher rate of development and the introduction of new technological advances. The mechanism of local appeals for certain types of development in hospital and health services was considered to be an interesting way of tapping additional resources.

In the National Health Service of the UK since the Ceri Davies (1982) and Griffiths (1983) reports, there has been growing recognition that estate is one of the key resources which can be used to provide better patient care. The committee on the levy of medical tax constituted by the government of Andhra Pradesh in their report in 1979 opined that augmentation of budgetary resources is essential for further development of medical and health services. The committee favoured a system of fee for out-of-turn service and special services in order to mobilise additional resources.

Medical and nursing care are only important constituents of the full range of services which constitute the hospital service to the public. For example, supporting services like building premises maintenance, water and electricity are very important contributers to patient comfort. If not maintained properly they can also adversely affect the quality of medical and nursing care. Traditionally, in Andhra Pradesh as well as many other states in India, these services are the responsibility of departments like roads and buildings, which are given charge of the maintenance of a large variety of buildings.

As hospital buildings are put to continuous use, they need frequent repairs and as a result the medical administrator has regularly to co-ordinate with these authorities. This co-ordination is usually not very effective due to various factors like differences in perception on maintenance priorities, work procedures, budgetary provisions, and so on. As a result, the medical administrator finds himself a helpless spectator to deterioration in supportive services of the hospital. As a result some amount of operational autonomy in management of support services is required for efficient functioning of the hospitals.

The efficient functioning of the hospitals will depend to a large extent on the amount of funds available for the purpose. However, availability of funds cannot be considered an indication of the efficiency of the institutions themselves. The amount of resource sub-allocation is important since it determines the goals and missions of the hospital. Due to the size and complexity of state budgets, it is not usually possible to ensure appropriate sub-allocation of resources in the hospital sector, through it fulfils its primary role of determining the priority of hospitals in relation to other sectors, very competently. Hence some amount of operational autonomy in sub-allocation of resources to suit the peculiar needs of the hospitals is essential.

It is well recognised that a large share of the health services expenditure is being spent on hospitals. The hospitals generally harbour the better part of the health professionals in the country. In spite of all these positive aspects, hospitals have fallen short of achieving their objectives. This is mainly due to ineffective management of human and other resources of the hospital. While industries have developed good management techniques over a period of time, hospitals have lagged behind in this field. There is the need for developing a proper framework and methodology of management development in hospitals.

In order to achieve the goal of providing appropriate and high quality of health care at a reasonable cost, better organisation and administration of human and other resources are important. Lack of proper management development in our hospitals has resulted in the problems of delegation of authority and responsibility. Very often authority remains with the management and tasks are delegated to subordinates. It is being increasingly realised that management training alone for health personnel may not be sufficient to achieve the objectives. What is needed is management development. According to this concept, besides improving the managerial capabilities of the manager, the management practices and culture of the organisation or the system are also changed and improved.

Against the above background, the government of Andhra Pradesh brought in legislation for the establishment of Andhra Pradesh Vaidya Vidhana Parishad (APVVP) in 1986.

The APVVP is a statutory autonomous body established by an act of legislature. The act provides a reasonable degree of operational autonomy to the commission. It provides for participation of members of

the medical profession in the management of the hospitals through the governing council, chief executive and committee of professionals.

Thus APVVP is a unique step by the government of Andhra Pradesh in the following respects:

- Development of secondary level hospital services
- Broader resource base for development of hospital services
- Operational autonomy in the hands of the medical profession, and
- Scope for management development in hospitals.

The APVVP came into existence on 1 November 1986 and started managing the secondary level hospitals in the state from 1 March 1987.

In effect it is a directorate of first referral and district level hospital services in the state. This will enable the staff to bestow specific attention on secondary level hospital services. The Parishad can also specialise in the development of management techniques for hospital administration. The act also envisages multiple channels of mobilisation of resources for the purposes of further development of hospitals. □

References

1. Chester TE, Hospitals at first-referral level, *International Hospital Federation Official Year Book 1988,* pp180 Sterling Publications, London.
2. Hardie M, What the future holds for hospitals, *International Hospital Federation Official Year Book 1986,* Sterling Publications, London.
3. Vertio H, The hospital's role in health promotion, *International Hospital Federation Official Year Book 1988,* Sterling Publications, London.
4. Montoya–Aguilar C, The hospital of the future, *International Hospita Federation Official Year Book 1986,* Sterling Publications, London.
5. Ghei PN, The role of hospitals in PHC in Dehli, *International Hospita Federation Official Year Book 1985,* Sterling Publications, London.
6. Taylor CE, Health Services Research – How hospitals can help primar health care, *Background papers on Planning and management of medic care and hospital services,* National Institute of Health & Family Welfar New Delhi, India.
7. Yesudium CAK, Proceedings of the workshop on management develo ment in the hospital, *The Indian Journal of Social Work,* Vol XHV No April, 1984.
8. Morris KS, Hospital Financing Systems, *International Hospital Federati Official Year Book 1985,* Sterling Publications, London.
9. Idris Pearce DN, Rationalising the National Health Services estate, lessc for the public sector, *Public Administration, Vol. 66,* Winter 1988, pp4 455.
10. Government of Andhra Pradesh, Report of the committee on the Medi University levy of cess, Rural services and Employment of Doctors, 19 constituted vide GOM No 169 Health, 3 March 1979.
11. The APVVP Act No 29 of 1986, *Andhra Pradesh Gazette* Part IV Extraordinary No 36, 18 August 1986.
12. The APVVP (Amendment) Act No 5 1987, Act No 5 of 87, *AP Gazette* IV Extraordinary No 6, 4 February 1987, Govt of AP notification GOM 703 HM & FW (C1) Dept, 28 October 1986.
13. Health for All: An alternative strategy, Report of a study group set up jo by ICSSR and ICMR, New Delhi, 1980.