Asian Journal of Management Sciences

RESEARCH ARTICLE

Received on: 10-10-2013
Accepted on: 15-10-2013
Published on: 18-10-2013

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Evolution of Hospitals and its Management

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ABSTRACT

The researcher intends to study evolution of hospitals from as early as 4000 BCE till the recent hospitals of today. In context to medicine management, patient management, ownership, and general management rich historical evidence is revealed. The researcher also highlights the areas of management in today's era.

Keywords: Hospitals, medicine management, patient management, ownership, and general management.

Conflict of Interest: None Declared !

Cite this article as:
Nusrat N.Khan
Evolution of Hospitals and its Management
Asian Journal of Management Sciences 01 (01); 2013; 12-21.

1. INTRODUCTION

Early History of Hospitals

As early as 4000 BCE, religions identified certain of their deities with healing. The temples of Saturn, and later of Asclepius in Asia Minor, were recognized as healing centres. Brahmanic hospitals were established in Sri Lanka as early as 431 BCE, and King Ashoka established a chain of hospitals in Hindustan about 230 BCE. Around 100 BCE the Romans established hospitals (valetudinaria) for the treatment of their sick and injured soldiers,gladiators, chariotors, their care was important because it was upon the integrity of the legions that the power of ancient Rome was based.

In ancient cultures, religion and medicine were linked. The earliest known institutions aiming to provide cure were Egyptian temples. Greek temples dedicated to the healer-god Asclepiads might admit the sick, who would wait for guidance from the god in a dream. The Romans adopted his worship. Under his Roman name Esculapius, was provided with a temple (291 BC) on an island near the Tiber River in Rome, where similar rites were performed.

The loss of monastic hospitals in England caused the secular authorities to provide for the sick, the injured, and the handicapped, thus laying the foundation for the voluntary hospital movement. The first voluntary hospital in England was probably established in 1718 by Huguenots from France and was closely followed by the foundation of such London hospitals as the Westminster Hospital in 1719, Guy's Hospital in 1724, and the London Hospital in 1740. Between 1736 and 1787, hospitals were established outside London in at least 18 cities. The initiative spread to Scotland, where the first voluntary hospital, the Little Hospital, was opened in Edinburgh in 1729.

The early hospitals were primarily almshouses, one of the first of which was established by English Quaker leader and colonist William Penn in Philadelphia in 1713. The first incorporated hospital in America was the Pennsylvania Hospital, in Philadelphia, which obtained a charter from the crown in 1751.

History of Hospitals (1800-2012)

Upto 18th century Vaidyas and Hakims were the order of the day. University of Takshilla and Nalanda taught medicine. In the times of King Ashoka , Chola and Pandya Kings and Mughal Emperors hospitals were set up for the welfare of people. The use of Allopathic medicine started after the British missionaries came to India, in the sixteenth century. Eighteenth-century London was for many an unhealthy place to live, but there was growing institutional provision for curing the sick and the lame. In addition to the extensive care available through the parish (available from parish nurses and workhouses), and a variety of more or less qualified doctors. By 1800, when London hospitals catered for between twenty and thirty thousand patients a year Andrew, Donna T. Philanthropy and Police: London Charity in the Eighteenth Century. Princeton, 1989.

Nineteenth century hospitals were not places where you expected to be cured, they were places to go when all other options had been exhausted. In the early part of the century medical science was very crude, and often consisted of cures like bloodletting, where the doctor cut the veins of the patient to let bad blood escape. In some cases the best outcome you could expect was that the cure wouldn't kill you. It wasn't until the latter part of the 1800's that researchers began to understand how to deal effectively with illness and disease.

20th Century Hospitals as we know them today began to emerge in most of the country in the early- to mid-1800's, a bit earlier than the voluntary and non-profit old-age homes. Some early hospitals included care for the elderly as a part of their mission, even building homes attached to the hospital where the poor elderly could live. (Medical History of Michigan, 1930).

Unlike the younger, healthier patients, poorhouse patients tended to have chronic conditions that required long term care. People who weren't poor cared for the chronically ill at home. Those who were poor and ill, many of whom were also elderly, often ended up in hospitals for very long periods of time. (Charity Hospital, 1890).

In the early 21st century, it was thought that a facility of 800 beds was the largest unit that could be governed satisfactorily from a single administrative unit while maintaining a corporate unity.

In many countries nearly all hospitals are owned and operated by the government. In Great Britain, except for a small number run by religious orders or serving special groups, most hospitals are within the National Health Service. The local hospital management committee answers directly to the regional hospital board and ultimately to the Department of Health and Social Security. In the United States most hospitals are neither owned nor operated by governmental agencies. In some instances hospitals that are part of a regional health authority are governed by the board of the regional authority, and hence these hospitals no longer have their own boards.

Hospitals that specialize in one type of illness or one type of patient can generally be found in the developed world. In large university centers where postgraduate teaching is carried out on a large scale, such specialized health services often are a department of the general hospital or a satellite operation of the hospital. Changing conditions or modes of treatment have lessened the need or reduced the number of some types of specialized institutions; this may be seen in the cases of

tuberculosis, leprosy, and mental hospitals. On the other hand, specialized surgical centers and cancer centers have increased in number.

Dr. A.K. Malhotra in his book 'Hospital Management' by Global India Publications New Delhi. 2009, has mentioned that The British were instrumental in buiding hospitals in India. The first hospital was built in Goa and then Madras, Calcutta Delhi and Mumbai in 1874, where even the Portugese were instrumental. In the 19th century Modern Medicine took a firm root, Nursing came into being. Medical care spread all over India first by foreign funding then later by local funding as the importance of Hospitals grew. Organized medical training was started by the East India Company and they established a medical college at Calcutta and later at Madras. At the end of the 19th century there were 4 medical colleges in India and Hospitals took an organized structure as people realized that it is not a place to place the sick.

In the early years of 20th century more efforts were made to govern Hospitals in an organized way by transferring their administration from Public assistance powers of Local Administration committees to Health Administration Committees called as Public Health Hospitals. The Military hospitals which were started for treating only soldiers were now transferred to Civil Administration where even the civilians were availing of treatment. Local government were encouraged to start hospitals at the district and Taluka levels. The Indian Medical Service (IMS) ran many of these hospitals. Some hospitals at the provincial headquarters were converted into teaching hospitals and attached to medical colleges.

Between World War I and II reorganization of hospitals took place by starting Commisions of Enquiry. Rehabilitation centers and Fitness centers were established, these centers did commendable work in surgery and medical treatment as well.

19th century

English physician Thomas Percival (1740-1804) wrote a comprehensive system of medical conduct, Medical Ethics, or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons (1803) that set standards.

During the nineteenth century, the Second Viennese Medical School emerged with the contributions of physicians such as Carl Freiherr von Rokitansky, Josef Skoda, Ferdinand Ritter von Hebra, and Ignaz Philipp Semmelweis. Basic medical science expanded and specialization advanced. Furthermore, the first dermatology, eye, as well as ear, nose, and throat clinics in the world were founded in Vienna, being considered as the birth of specialized medicine.

By the mid-nineteenth century most of Europe and the United States had established a variety of public and private hospital systems. In continental Europe the new hospitals generally were built and run from public funds. The National Health Service, the principle provider of health care in the United Kingdom, was founded in 1948.

United States

In the United States the traditional hospital is a non-profit hospital, usually sponsored by a religious denomination. One of the earliest of these almshouses in what would become the United States was started by William Penn in Philadelphia in 1713. These hospitals are tax-exempt due to their charitable purpose, but provide only a minimum of charitable medical care. They are supplemented by large public hospitals in major cities and research hospitals often affiliated with a medical school. The largest public hospital system in America is the New York City Health and Hospitals Corporation, which includes Bellevue Hospital, the oldest U.S. hospital, affiliated with New York University School of Medicine. In the late twentieth century, chains of for-profit hospitals arose in the United States. The decline in the membership of religious orders has changed the status of Catholic hospitals.

In the 2000s, modern private hospitals began to appear in developing countries such as India.

While hospitals, by concentrating equipment, skilled staff and other resources in one place, clearly provide important help to patients with serious or rare health problems, hospitals also are criticized for a number of faults, some of which are endemic to the system, others which develop from what some consider wrong approaches to health care.

One criticism often voiced is the industrialized nature of care, with constantly shifting treatment staff, which dehumanizes the patient and prevents more effective care as doctors and nurses rarely are intimately familiar with the patient. The high working pressures often put on the staff can sometimes exacerbate such rushed and impersonal treatment. The architecture and setup of modern hospitals often is voiced as a contributing factor to the feelings of faceless treatment many people complain about.

Development of Hospitals after Independence in India.

After Independence there was growth of industrialization and population expansion which caused a lot of medical and health problems. At that time there were 7400 hospitals and dispensaries in India there were 1,13,000 beds, 19 medical colleges and 19 medical schools in India. Considering the rise in poverty and limited resources Committees like the Bhore Committee, Mudaliar Committee, Jain Committee, Shrivastava Committee, Siddhu Committee, Rao Committee, Bajaj Committee.

According to Health Information India (1995-96) as on 1st January 1996 there were 146 medical colleges,

15,097 hospitals, 623819 beds admitting 30 million in patients every year. The out patients were countless. Out of these there were 421 rural hospitals, 10416 urban hospitals, 4473 government hospitals and 10289 private and voluntary, 335 local hospitals. The patient to bed ratio as suggested by Mudliar committee is 1 be per 1000 population but it is 0.67 which is below the required ratio. This will lead to overcrowding and mismanagement in hospitals. 6000-7000 beds need to be added every year to maintain the ratio.

History of Government and Private Hospitals (Year1800-2012)

Health care is a social sector and it is provided at State level with the help of Central Government. In the Constitution of India, health is a state subject. Central governments intervention to assist the state government is needed in the areas of control and eradication of major communicable & non-communicable diseases, policy formulation, international health, medical & para-medical education along with regulatory measures, drug control and prevention of food adulteration, besides activities concerning the containment of population growth including safe motherhood, child survival and immunization Program. Another major component of the central sector health programme is purely Central schemes through which financial assistance is given to institutions engaged in various health related activities. These institutions are responsible for contribution in the field of control of communicable & non-communicable diseases, medical education, training, research and parent -care.

Government hospitals are owned and governed by governments, State or Central. These hospitals rely on subsidies and grants for part of their operations and perform more charity than other hospitals. Because these hospitals are tax supported, government agencies are likely to monitor operations and have the authority to increase or decrease funding through budgeting processes. Other nonprofit hospitals are privately owned and usually community hospitals or physician group hospitals. Physician influence tends to be stronger in these hospitals. These hospitals rely also on patient fees and public donation.

Hospital Management provides a direct link between healthcare facilities and those supplying the services they need. This procurement and reference resource provides a one-stop-shop for professionals and decision makers within the hospital management, healthcare and patient care industries.

A hospital is a health care institution providing patient treatment by specialized staff and equipment.

Government of India website data from the Health ministry site upto 2009 mentions that Eleven thousand six hundred and thirteen (11,613) allopathic hospitals are existing in India. Today the total value of the healthcare sector is 6% of GDP. 15,393 Hospitals were there in year 2002 in India.

Indian Scenario

A recent study in India indicates that healthcare is delivered by a multitude of public and private providers. The government infrastructure is large in both rural and urban India. In rural areas, the government has a vast base of primary healthcare centers, community health centers and sub centers. The public infrastructure in urban India consists of tertiary medical colleges, district and taluka hospitals and urban health posts. The private healthcare delivery sector consists of a large number of private practitioners, for profit hospitals and nursing homes and charitable institution. The average size of such hospitals is less than 22 beds-much lower than developed countries.

The purpose of for profit, investor owned hospitals was primarily to increase the value of invested capital. Prior research finds that for profit hospitals tend to locate in more profitable areas and are smaller than nonprofit hospitals. For profit hospitals obtain fewer donations and are not tax subsidized and so rely primarily on patient fees. Church hospitals are owned and governed by religious organizations; they were originally organized to provide services for church members, to restrict procedures that are contrary to religious beliefs and to permit patients to follow the tenets of the religion for last rites and other ceremonies. These hospitals rely on both patient fees and donations. Government hospitals are owned and governed by governments, State or Central. These hospitals rely on subsidies and grants for part of their operations and perform more charity than other hospitals. Because these hospitals are tax supported, government agencies are likely to monitor operations and have the authority to increase or decrease funding through budgeting processes. Other nonprofit hospitals are privately owned and usually community hospitals or physician group hospitals. Physician influence tends to be stronger in these hospitals. These hospitals rely also on patient fees and public donation.

Non profit firms may earn profits. In fact, many, including hospitals, do. Rather nonprofit firms are precluded from distributing profits to persons who exercise control over the firm. Although such firms can pay reasonable compensation to suppliers of inputs, resulting earnings cannot be distributed. Such earnings must be retained and used by the firm. Because of the non distribution constraint, nonprofit firms have no owners, that is, persons who control and share residual earnings.

Ownership form and hospital behavior: The social welfare implications of for-profit versus nonprofit ownership, and private versus public ownership, have

been of interest to economists for decades. In stylized microeconomic models of organizations, theory predicts that the for profit organizational form is efficient because of the high powered incentives that arise from the presence of a well defined residual claimant with legally enforceable property rights. Researchers exploring the effects of for profit, private, non-profit and public hospital ownership on productivity have reported a wide range of empirical results. On one hand, some researchers report that the for-profit form achieves greater productive efficiency, on the other hand, many studies find that for-profit hospitals have higher costs or markups than do nonprofits. And a substantial literature argues that nonprofit hospitals have costs and /or quality similar to that of for profits, concluding that hospitals are socially indistinguishable on the basis of ownership status.

In India too, the above conclusion stands true. There are hospitals both in the private and public who extend service quality par excellence. Due to the unregulated system, there are also the extreme cases of poor quality healthcare provided by hospitals, many operating with unskilled medical staff and in substandard facilities.

Rather than the ownership model, it would be prudent to mention that the leadership and the resultant vision, mission and goals of the organization, is what determines the outcome and its quality in an organization.

Hospital Management

History of Hospital Management (Year 1800-2012)

Medicine and surgery date back to the beginning of civilization because diseases preceded humans on earth. Early medical treatment was always identified with religious services and ceremonies. Priests were also physicians or medicine men, ministering to spirits, mind and body, Priests/doctors were part of the ruling class with great political influences and the temple/hospital was also a meeting place.

Medicine as an organized entity first appeared 4000 years ago in the ancient region of Southwest Asia known as Mesopotamia. Between the Tigris and Euphrates rivers, which have their origin in Asia Minor and merge to flow into the Persian Gulf.

The first recorded doctor's prescription came from Sumer in ancient Babylon under the rule of the dynasty of Hammurabi (1728-1686BC). Hummurabi's code of law provides the first record of the regulation of doctors 'practice, as well as the regulation of their fees. The Mesopotamian civilization made political, educational, and medical contributions to the later development of the Egyptian, Hebrew, Persian and even Indian cultures.

For Hundreds of years, the Greeks enjoyed the benefits of contact and cross fertilization of ideas with numerous other ancient peoples, especially the Egyptians. Although patients were treated by magic rituals and cures were related to miracles and divine intervention, the Greek recognized the natural causes of diseases and rational methods of healing were important. Hippocrates is usually considered the personification of the rational non-religious approach to medicine, and in 480 BC, he started to use auscultation, perform surgical operations and provide historians with detailed records of his patients and descriptions of diseases ranging from tuberculosis to ulcers. The temples of Saturn, Hygeia and Aesculapius, the Greek god of medicine all served as both medical schools for practitioners and resting places for patients under observation or treatment.

The Roman talent for organizations did not extend as readily to institutional care of the sick and injured. Although infirmaries for the sick were established, it was only among the military legions that a system for hospitalization was developed. After the injured were cared for in field tents, the soldiers were moved to valetudinarians, a form of hospital erected in all garrisons along the frontiers. Apparently those stone and wooden structures were carefully planned and were stocked with instruments, supplies and medications. The decree of Emperor Constantine in 335 AD closed the Aesculapia and stimulated the building of Christian hospitals. Around 370AD St Basil of Caesarea established a religious foundation in Cappadocia that includes a hospital, an isolation unit for those suffering from leprosy and buildings to house the poor, the elderly and the sick. Following this example similar hospitals were later built in the eastern part of the Roman Empire. Another notable foundation was that of St Benedict at Monte Cassino, founded early in the 6th century, where the care of the sick was placed above and before every other Christian duty. It was from this beginning that one of the first medical schools in Europe ultimately grew at Salerno and was of high repute by the 11th Century. This example led to the establishment of similar monastic infirmaries in the western part of the empire.

The development of efficient hospitals was an outstanding contribution of the Islamic civilization. The Roman military hospitals and the few Christian hospitals were no match for the number, organization and excellence of the Arabic hospitals. The Arab's medical inspiration came largely from the Persian Hospital in Djoundisa bour (sixth century Turkey), at which may of them studied. Returning to their homes, they founded institutions that were remarkable for the times. During the time of Mohammed, a real system of hospitals was developed. He was the first to order the establishment of small mobile military Bimaristan (hospital) .Asylums for the insane were founded ten centuries before they first appeared in Europe. In addition, Islamic physicians were responsible for the establishment of Pharmacy and chemistry as sciences.

Some of the best known of the great hospitals in the middle Ages were in Baghdad, Damascus and Cairo. In particular, the hospitals and medical schools of Damascus had elegant rooms, an extensive library and a great reputation for its cuisine. Separate wards were set aside for different diseases, such as fever, eye conditions, diarrhea, wounds and gynecological disorders. Convalescing patients were separated from sicker patients and provisions were made for ambulatory patients. Clinical reports of cases were collected and used for teaching.

Indian Hospitals.

Historical records show , especially the Chinese traveler Fa Hein who reported in his books, that efficient hospitals were constructed in India by 600 BC. During the splendid reign of King Asoka (273-232 BC), Mughal emperor Feroz Shah Tughlaq. Indian hospitals started to look like modern hospitals. They followed principles of sanitation and cesarean sections were performed with close attention to technique in order to save both mother and child. Physicians were appointed –one for every ten villages-to serve the health care needs of the populations and regional hospitals for the infirm and destitute were built by Buddha.

The middle Ages: Religion continued to be the dominant influence in the establishment of hospitals during the middle age. From the early fourth century to the fifteenth century trade was almost totally suppressed and many city dwellers returned to the land. Religious communities assumed responsibility for care of the sick. The rational nonreligious approach that characterized Greek medicine during the era of Hippocrates was lost, as hospitals became ecclesiastical, not medical institutions. Only the hopeless and homeless found their way to these hospitals, in which the system of separation of patients by diseases was eliminated, three to five patients were accommodated in each bed and principles of sanitation were ignored. Surgery was avoided, with the exception of amputation, in order not to disturb the body and to avoid the shedding of blood per the church edict of 1163 that, in effect, forbade the clergy from performing operations. Religious order emphasized nursing care, the first religious order devoted solely to nursing is considered to be the St Augustine nuns, organized in approximately 1155.

Yet hospital construction increased in Europe during the middle Ages for two reasons. First, Pope Innocent III in 1198 urged wealthy Christians to build hospitals in every town and second, increased revenues were available from the commerce with the crusaders. The oldest hospital still in existence are the Hotel –Dieu in Lyons and Paris, France. The term Hotel-Dieu indicates that it is a public hospital. The earliest mention of the Hotel –Dieu in Lyons is found in a manuscript of 580 AD, in which its establishment by Childebert is recorded. The Hotel-Dieu of Paris was founded by Bishop Landry in 660, on the LLe de la Cite. In 1300, the hospital had an attending staff of physicians and surgeons caring for 800-900 patients, and its capacity was doubled in the fifteenth century. In these hospitals more attention was given to the wellbeing of the patient's soul than to curing bodily ailments. The growth of hospitals accelerated during the crusades, which began at the end of the 11th century. Pestilence and disease were more potent enemies than the Saracens in defeating the crusaders. Military hospitals came into being along the traveled routes: the knights Hospitalers of the Order of St John in 1099 established in the Holy Land, a hospital that could care for some 2000 patients. It is said to have been especially concerned with eye disease and may have been the first of the specialized hospitals. This order has survived through the centuries as the St John's Ambulance Corps.

In contrast, in Asia and Africa, during the same period, construction of effective and efficient hospitals was spurred by Islamic rule and the Crusades. The two hospital systems enforced sanitary measures ,performed surgery and separated patients according to disease: the Islamic hospitals because they were still following the Greek and early Roman traditions, and the hospitals created by the Crusaders because injuries sustained in combat necessitated surgery and the presence of pests and contagious disease necessitated sanitary conditions and the strict separation of patients. For the first time, medical systems of the East and the West vied for the supremacy of medical care. Arab hospitals were notable for the fact that they admitted patients regardless of religious belief, race or social order.

Renaissance Age:

The renaissance period lasted from the fourteenth to the sixteenth centuries. It received its name from the Italian "rinascita" meaning rebirth, because of the common belief that it embodies a return to the cultural priorities of ancient Rome and Greece. The healing arts were again characterized by a scientific, rational approach. The period also saw the beginnings of support for hospital like institutions by secular authorities. Toward the end of the 15th century many cities and towns supported some kind of institutional healthcare: it has been said that in England there were no less than 200 such establishments that met a growing social need. The gradual transfer of responsibility for institutional healthcare from the church to civil authorities continued in Europe after the dissolution of the monasteries in 1540 by Henry VIII, which put an end to hospital building in England for some 200 years. Only the powerful hospitals in London survived when the citizens petitioned the King to endow St Bartholomew,

St Thomas and St Mary of Bethlehem hospitals. This was the first instance of secular support of hospitals.

The loss of monastic hospitals in England caused the secular authorities to provide for the sick, the injured and the handicapped, thus laying the foundation for the voluntary hospital movement. The first voluntary hospital in England was probably established in 1718 by Huguenots from France and was closely followed by the foundation of such London hospitals as the Westminster hospital in 1719, Guy's hospital in 1724 and the London Hospital in 1740. Between 1736 and 1787 hospitals were established outside London in at least 18 cities. The initiative spread to Scotland where the first voluntary hospital, the little Hospital, was opened in Edinburgh in 1729.

If the middle ages can be seen as the period of the great hospitals, the renaissance was really the period of the great school of medicine. Schools of medicine flourished in Germany and in central and eastern Europe. The scientific study of human anatomy as a science were facilitated by dissections of animals. In 1506, the Royal College of Surgeons was organized in England, followed by organization of the Royal College of Physicians in 1528. The major contribution of the Renaissance to the development of hospitals was in improved management of the hospital, the return to the segregation of patients by disease, and the higher quality of medicine provided within the hospital. Clinical surgery took great strides during this period, not only in Italy but also in France, especially under Ambrose Pare, who introduced the ancient methods of stopping hemorrhage by using ligatures and abandoned the barbaric system of cauterizing irons. The academic world of northern Italy was tolerant of new cosmopolitan ideas. By the mid fifteenth century, all major courts and cities of Europe sent their finest physicians to Italy for advanced training.

The New Era

The first hospitals of the New World were built in colonies of Spain, France and England. Those built under the flags of Catholic Spain and France retained the ideals of the Jesuits, the Sisters of Charity and the Augustine Sisters and their hundreds of years of hospital knowledge. Hospitals built in the English colonies, however, reacted against English traditions.

The first hospital in the New World was constructed as part of a system for the occupation of over seas territories. Bartholomew de las Casas, one of the priests who accompanied Columbus on his first voyage and a well known historian referred to the founding of the village of La Isabella in Hispaniola(today, Santo Domingo), in January of 1494. Columbus made haste in constructing a house to keep supplies and the ammunition for the soldiers, a church and a hospital. No further information survives to indicate whether the hospital was actually built.

The first hospital in North America was built in Mexico City in 1524 by Cortes: the structure still stands. The French established a hospital in Canada in 1639 at Quebec City, the Hotel Dieu du Precieux Sang, which is still in operation although not at its original location. In 1644 Jeanne Mance, a French noblewoman, built a hospital of ax-hewn logs on the island of Montreal; this was the beginning of the Hotel Dieu de St Joseph, out of which grew the order of the Sisters of St Joseph, now considered to be the oldest nursing group organized in North America. The first hospital in the territory of the present day United States is said to have been a hospital for soldiers on Manhattan Islands, established in 1663. The early hospitals were primarily almshouses, one of the first of which was established by William Penn in Philadelphia in 1713. The first incorporated hospital in America was the Pennsylvania Hospital, in Philadelphia, which obtained the charter from the crown in 1751. According to an inscription on its wall, the institution intended to foster patient's self respect and remove any stigma from a hospital visit by charging fees. Benjamin Franklin helped to design the hospital, which was built to provide a place for Philadelphia physicians to hospitalize their private patients. Franklin served as president from 1755 to 1757.

In another break from tradition the New York hospital was founded in 1771 by private citizens who formed the Society of the New York hospital and obtained a grant to build it. The hospital was characterized by a spirit of learning and research. As with other hospitals founded before the era of large fortunes, the New York hospital was built on the contribution of small merchants and farmers.

Another innovation was the first hospital conducted only by women. The New York Infirmary for Women and Children was opened in 1853 by the first woman to earn a medical degree in the United States, Elizabeth Blackwell and her sister. Again, this is another example of a private owned hospital that was founded to accommodate physician's needs.

The European and Latin American tradition of charity hospitals, based on love of God and neighbors and the conviction that the government owed a responsibility to helpless citizens was never a part of the US hospital traditions. As a result, a more competitive system of hospitals developed, with fewer subsidies and less involvement of religious organizations in total healthcare. Massive government involvement in healthcare began in 1926 with the return of veterans from World War I.

The magnitude of the industry has grown significantly in the past few decades as the history of hospitals already states.

The profession of hospital administration is unique because hospitals are unique organizations where professionals are working in a life and death activity and to manage this the professionals require high level of skill. Hence hospital administration evolved as a discipline over a period of time where very few formally trained hospital administrators are available in the developing countries, while most of the hospitals are being managed by managers who had on the job training and managing by the principle of traditional approach. Though hospitals have administrative and service functions that are common to other commercial enterprises, but it requires integrating with highly technical and clinical services with administrative and service departments like laundry and hospital engineering services functioning alongside highly technical, nursing and medical care activities. This variety and complimentary are what make hospital administration a difficult job.

In the 18th century hospital administrators were selected from the rank of nursing service and registered nurses had been serving as hospitals head administrator. In Church hospital administrator was frequently selected from the rank of religious order.

In mid 1930 first formal university course for hospital administration was developed. The American College Hospital Administration (ACHA) is an organization that has influenced advancement of the profession of hospital administration. After World War II the field of hospital administration gained status as the need for formally trained hospital administrators increased, however the situation in developing countries including India is grim as hospital administration as a profession is still in infancy due to non availability of trained hospital administrator and pressure from clinicians to hold seat of authority. In 1939 American College of hospital administration designed a code of Ethics for hospitals and healthcare executives, which defines as how healthcare executives should function within the highest standard of ethical performance. The code has since undergone several revisions in order to keep pace with change in the profession. The clinician and practicing physicians are taking grater role in hospital management and decision making process because it affects their professional lives and these clinicians are ever taking management roles hospitals full time medical director.

The main task of hospital administer is to coordinate hospitals resources in order to fulfill institutes medical care objective in the most effective and efficient way possible. He should manage personnel, materials, equipment and finances and is responsible foe all functions including medical staff functions, nursing, technical and general service activities.

The hospital administrators of the 1940s and 1950s were primarily concerned with institutions internal operation and those activities directly supporting care of hospitals patients. The hospital industry changed dramatically subsequently in the 20th century as many Governmental regulations came into existence. The hospital administrator has now two roles to perform, firstly managing those activities that went on in a hospital and secondly to participate in community activities and assess the needs of the community as these influence hospitals functioning. The hospital administrator of today 21st century is also the public relations officer and is also educating community about hospitals to make hospital more acceptable by community. He also monitors quality of medical care in the hospital provided by medical professionals. This is the era of sub and super specialties, and Information Technology. The hospital works as per rules, regulations, policies and guidelines laid down by hospital board and administration. The hospitals are managed by the principles of Total Quality Management (TQM). The concept of Medical Record is in reality now.

The management and administration includes:-

- Diagnosis, Prevention: Here various tests are conducted like x-ray, MRI, blood and urine tests, bone marrow tests, sonography, blood sugar, blood pressure, heart tests like stress test, 2-D Echo, 3-D Echo, Color Doppler, physical examinations like heart beat per minute, color of eyes etc.
- Treatment: It could be only medical management, may sometimes include some procedures surgical or laser treatment, physiotherapy, radiology etc.
- Post discharge care and rehabilitation: Where the patient is given guidance and advice about lifestyle management, diet, further medication etc.
- Information: In the right to information the patient must know about the tests, procedures conducted on him the risks, cost, side effects, recovery period etc. But sometimes in the interest of the patient some facts may be hidden from him and told to his relatives and nearest in kin.
- Medico legal cases. Where cases like burns, suicide, homicide, genocide, accidents, fights, a separate management is done where records have to kept of the FIR lodged, statements of the patient etc. Ideally this information is to be stored for five years minimum and maximum 10 years as an aid to the investigation procedures of the police, till the case has been declared as solved.
- Staffing: Hospitals are labor intensive. In 1982 labor costs averaged 56.7% of operating expenses. Hospitals employ people with a wide variety of skills. The range goes from an unskilled janitor or food service worker to the most highly educated and specialized

paraprofessional and professionals who are highly specialized in different areas or fields.

- Management Control: The regular planning, controlling, budgeting, motivating will also be regular procedures.
- Accounting: Staff payroll salaries (visiting or in-house), professionals and para-professionals, nurses, ward boys, cleaners, sweepers, cooks, laundry men, technicians, ambulance drivers. Bed occupancy is studied as empty beds signify bad business. Billing of patients, checking insurance type, reimbursements etc.
- Inventory: Stock control of all inventories in the hospital like medicines, surgical and non surgical instruments like stethoscope, injections, saline bottles etc. Also the beds, tables, bed covers, curtains etc.
- Purchase Order: The regular purchase for medicines, housekeeping items like bed sheets curtains, surgical, non surgical instruments from regular suppliers or through tenders.
- Blood Banks: Regular update of blood in the bank. Organizing blood donation camps. Getting the blood samples checked for HIV, hemoglobin and other irregularities, monitoring and storing in requisite condition.
- Marketing: Though medical ethics disallow advertising of any sort but even then indirect advertising like having awareness camps, lectures from renowned foreign doctors, conferences, seminars, free checkups, splashing the same on radio, television are goodwill generation and publicity measures for the hospital, highlighting its areas of specialization and facilities offered.
- Research: Many hospitals are a center for research of various sorts in treatment, medicines clinical research, clinical psychology etc. which is largely useful to society.
- Teaching Affiliation: A number of community hospitals are affiliated with training programs for physicians, nurses or other health care givers. Some hospitals are academic medical centers owned by state or private universities, where education and research as well as health care are primary goals. Many hospitals are totally government run and charitable, and services are of utmost importance. Many people give huge donations to hospitals.
- Quality assurance: Ethics as well as a financially prudent management perspective to avoid malpractice settlements, require that managers of hospitals be certain that the care provided is at an acceptable level of quality. In health care and related industries the consumer is not in position to evaluate the quality the service from a clinical point of view. In addition, the consequences of the lack of quality can have far reaching effects, since the product is the patients well being and perhaps his life. Hence care is to be taken by the government and guardians of the hospital, to assure that quality is of an adequate level.
- Financing health care: The primary source of payments to hospitals is through third-party payment. Only 10% payments are through self pay. Others are blue cross payments-30%, government agencies (Medicare, Medicaid etc.)- 30%, Commercial and independent insurance – 30%. Most people are covered by some form of health insurance either cashless or reimbursement type. These records have to be maintained and verified[1].
- Legislation and regulation: The external environment is important to any organization. One of the principal components of the external environment of the hospital industry is regulation. Regulations affecting the health care industry are not only governmental; hospitals are also subject to regulation by private agencies that set standards for accreditation or membership. Within the hospital, increasing regulation has the effect of reducing decision latitude of the administrator and the board of trustees and the medical staff. The hospital administrator must be aware of central, state and local regulations which influence financial management of a hospital, the amount of services offered, or the amount and use of resources available to provide these services. Medico-legal cases may also fall in this category, where the police and court come into the picture.
- Tie-ups or registration of hospitals under various government and industrial or organizational health care facilities or schemes to provide better health care for their employees. Notified or registered hospitals under various government and private health insurance schemes.
- Privacy and security of Data: The security aspect will be regarding the data of the patients that is stored with the hospitals. According to medical ethics where details of diagnosis of patients is concerned a very high level of secrecy is to be maintained. As can be explained some psychological disorder in the past, some contagious disease suffered by the patient which is now cured. Some medico legal case he has been involved in. These are the kind of things which in India even now people don't accept easily. Even where ethics are concerned a doctor will never discuss one patient's case with the other patient of acquaintance. To quote an experience an elderly lady working in an organization went to the family doctor, when the doctor was asked what was wrong with the lady, he very strictly told he could not share that. Also a case in Philips India where the medical officer, a doctor, was called upon to enquire about the medical details of one of the laborers, very vehemently

denied to tell the senior officer any details except how many days he was required to rest. The computer with its passwords, encryption and restricted access to private data will be a very effective way of keeping data safe. Even Biometrics is a security mechanism, medico legal cases would require this, as that data is prone to tampering by parties with vested interests.

- On-line diagnosis: Many doctors offer online diagnosis on their own and also with the help of the technology of ARTIFICIAL INTELLIGENCE. Some software are available e.g. Eliza and Mycin with the help of the internet a patient can communicate with the doctors overseas or distant places where they want to seek second opinion or the diagnosis of the renowned doctor. He can send his test reports through computer network, using a scanner and seek his guidance on the line of treatment and medical facilities and possibilities available in some areas of the globe or his country which he may not be aware of earlier.

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