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# **Organization of Indian Health Bureaucracy and its Delivery System**

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## **Abstract**

The aim of this paper is to probe into the structure and functioning of health bureaucracy in India with specific reference to rural health bureaucracy of Tamil Nadu State. bureaucracy is defined as "a hierarchical division of staff who act on formal assignments" - Gouldner(1954). This definition suggests five specific dimensions of bureaucracy namely (i) hierarchical structure (ii) nature of work and progress (iii) procedural devices (iv) decision making and (v) procedural bottlenecks have been considered in this order to understand the functioning of bureaucracy. These factors are particularly relevant to the understanding of bureaucratic functioning as the previous studies have indicated that the magnitude of these attributes varies from one organization to another (Hall, Peabody, Meyer) 1. The functional complexities of any bureaucratic system largely depend upon the combination of these attributes (Bennis).

Health care delivery system is a system in which the services related to health care delivered to the target population. In Health care the higher-level officials do only planning while the local staff do implementation. In India including Tamil Nadu, the implementing agency of health care programmes is at block level known as Primary Health Centers (P.H.C.).

In such a kind of setup, whether the centralised approach will be effective? Whether the mechanistic and vertical delivery system will achieve the health care to all sections of society? What are the merits and demerits of mechanistic model?

The paper would like to address the above questions in the present context. It also would like to present the health delivery of Non Governmental Organisations. The nature of hierarchy plays an important role in health. The centralised control created problem in managing emergencies. It was also found that the lower level officials need to be part of the planning process as the policies have to be customised.

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# **Organization of Indian Health Bureaucracy and its Delivery System**

**K.Srinivasan<sup>3</sup> and Raka Sharan<sup>4</sup>**

## **Introduction:**

The aim of this paper is to probe into the structure and functioning of health bureaucracy in India with specific reference to rural health bureaucracy of Tamil Nadu State, based on the fieldwork conducted during 1993-95. Since the discussions require to deal with bureaucratic elements, therefore it would not be out of way to have a glance at the concept of 'bureaucracy'. Bureaucracy is defined as "a hierarchical division of staff who act on formal assignments" - Gouldner(1954). This definition suggests five specific dimensions of bureaucracy namely (i) hierarchical structure (ii) nature of work and progress (iii) procedural devices (iv) decision making and (v) procedural bottlenecks have been considered in this order to understand the functioning of bureaucracy. These factors are particularly relevant to the understanding of bureaucratic functioning as the previous studies have indicated that the magnitude of these attributes varies from one organization to another (Hall, Peabody, Meyer). The functional complexities of any bureaucratic system largely depend upon the combination of these attributes (Bennis).

Hall, for example, observed that certain organisational activities are related to one or more of the above-mentioned dimensions. The attributes like division of labour, hierarchical structure and the type of decision-making have been found to be closely linked with one another. Similarly Lindblom concludes that the selection of goals and appropriate means are generally interwoven. Good policy can be formulated when decision makers find themselves in agreement.

As regards planning and coordination, Meyer's findings have revealed that the nature of work and supervisory positions determine the level of coordination and

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nature of planning. Some studies have noted that complexity of rules and procedures adversely affect bureaucratic efficiency.

All these studies are essentially centered around Weber's model, which presumes that these attributes are ideal for the functioning of any organization? Within this theoretical perspective the present analysis centres around a very broad query i.e. whether these attributes have implications for aspects like decision-making and overall organisational functioning. If so, then what is the functioning of the organizational set up under study.

The organizational functioning is being analysed here with a view to identify those attributes, which influence organizational effectiveness and decision-making.

Weber's model of bureaucracy characterised as an ideal typical model suggested the desired features of a bureaucratic structure on the basis of number of attributes. Max Weber, the master theoretician, found four major attributes of bureaucracy that marked it out for its advantages. They are efficiency, predictability, impersonality and speed. As an ideal type, it could possess all those attributes and perhaps more, at one point of time or all times. However, in sociological analysis of functioning of bureaucracy in transitional society like ours shows that no real society can have all attributes at one point of time. The ideal type attributes can work as a goal and one can desire to achieve them by putting proper efforts. However, it may not possible for a bureaucracy to have all of them at one point of time.

Further, Weber suggested some desirable elements of a bureaucracy, such as

- Hierarchical structure*: the lower officials are supposed to be supervised by the higher officials and there has to be a ring like structure in any bureaucratic organisation,
- Nature of work and progress,
- Procedural devises for recruitment of functionaries as well as policy - decisions,
- Decision - making and maintenance of all records,

- Procedural of bottlenecks and their solution.

The above features suggest that in a bureaucratic organization, there has to be some definite rules and procedures, and all officials of different levels are controlled by those rules and procedures. Further, it has been suggested that organization cannot perform its functions properly unless assignees are strictly appointed based on their merit and efficiency. Hierarchical structure needed to be maintained to provide proper supervision of lower staff by higher ones. The appointments and promotions have to be made on the basis of technical competence. Weber had given lots of importance to the process of selection of bureaucrats and had given some basic principles for their role-performance.

According to Weber each and every person working in an administration has to obey the officials who are superior to him/her. Also, the decisions made at the lower level have to be ratified by the superior officials. For Weber, an efficient administration must be able to have some schemes of distinct distribution of power allocation to different levels. However, it was observed in number of studies that the above scheme might create certain amount of malfunctioning (Bennis 1972).

### **The Organizational Structure of National Health Organization:**

India has a parliamentary system of government with a President, a Council of Ministers (Cabinet), 'a House of the people' (Lok Sabha) and a House of the States (Rajya Sabha). Administratively, the country is divided into Twenty Eight States and Seven Union Territories. In all, India is comprising of 602 districts (Most of them having a population between 1.25 to 1.5 million), which are further divided into smaller Tehsil or Taluk and Blocks each with population of 80,000 to 1,00 000 for taking care of development programs.

Under constitutional provision, health service is the responsibility of state governments. The responsibility of the Union Government is only confined to

international health, food quarantine, inter-state quarantine, research, and promotion of special studies and institutions. As the Union Government is also directly responsible for administration of the union territories, it is also directly responsible for running the health services in those territories.

The Union Government has established the Central Health Council, consisting of the Union Minister of Health and all the health ministers of the state governments (see figure 1.1). The council is, theoretically, an advisory body, but in practice it has assumed the form of supreme body of policy making for health with the Union Health Minister playing a dominant role.

Figure 1.1

Figure 1.1 suggests that the Union Minister of Health and Family Welfare holds the key responsibility for his ministry in the union Cabinet headed by the Prime Minister. One or more Ministers of State and Deputy Minister often assist the Union Minister.

The Union Minister of Health has a secretariat, which is known as Ministry of Health and Family Welfare. A secretary who is an administrator, usually belonging to the Indian Administrative Service (IAS) cadre, heads it. The Secretary happens to belong to a non-technical service and therefore he lacks in specialised kind of health training (medical). Therefore, he is a generalist administrator. Even though the secretary of health is not trained in technical aspects of health administration, it is felt that he possesses the political and social skills to assist the Minister to discharge his function in the cabinet and in the parliament as the political head of the Ministry (see figure 1.2).

Figure 1.2

Figure 1.3

The secretariat has a directorate of health services with specialists. The Director General of Health Services (DGHS) heads the directorate. The Directorate General of Health Services is called as 'attached office' of the Ministry. As the Union Government is associated with the maintenance and development of a very wide range of community health activities in the states, even within the circumscribed area of tendering expert advice to the Ministry, the office of the Director General of Health Services has officers who have competence, training and proper skill.

The secretariat is responsible for the key functions of policy formulation, planning and recruitment of personnel and financial administration. As it represents the views of the Union Government, the Secretariat also deals with its counterpart in the State Governments. Various Governmental, and Non-Governmental health Organizations as well as international agencies are affiliated to the Health Ministry.

There are two departments in the Ministry of Health and Family Welfare - the Department of Health and Department of Family Welfare. Each of these Departments is headed by an additional Secretary, who is assisted by other generalist administrators occupying different positions in the hierarchy- joint secretaries, directors, deputy-secretaries, under- secretaries, and so on.

In practice, however, the Ministry of Health and Family Welfare of the Union Government has much more power, as the state governments have to depend on it for finances. This financial power exerts some control over state governments through various agencies, particularly the National Planning Commission. The Union Government is responsible for taking care of international health and international relations. This enables the Union Government to make use of the resources made available by various international agencies and government and non-government organizations of foreign countries to ensure the cooperation of states in the health schemes proposed by the international agencies. The Union Ministry of Health and Family Welfare

initiated almost all major health programmes of the country, for example, the various vertical programmes, establishment of primary health centers, the family planning program, the multipurpose workers scheme and the community health workers' scheme. This asserts to its power to influence health services in the states.

### **Health Administration in Tamil Nadu**

Having discussed the national level health bureaucracy, now let us have a look at the state health organization of Tamil Nadu state. Tamil Nadu is a state in which the health organization is organized in a very coherent manner. The administrative pattern of the state is similar to that of the Union Government (See figure 1.3). A minister of health is responsible to the state cabinet headed by the 'Chief Minister' and the cabinet is collectively responsible to the state legislature. Again, a secretary heads the administration, who is a non-technical administrator belonging to the Indian Administrative Service (I.A.S.) cadre, assisted by the office of the top ranking health official. The Directorate of Health and Family Welfare Department is called as "Directorate of Medical and Rural Health Services" in Tamil Nadu. It has a status of 'attached office' to the state ministry. "The Directorate of Public Health and Continuing Education" is merged with the "Directorate of Public Health and Preventive Medicine" and called as, "The Directorate of Public Health and Preventive Medicine" (G.O. Ms. No. 25,HIMFW, dated, 3.1.91).

The above discussion shows that the structure of health services of this state is different from the central health services. Firstly, there is no dichotomy between the health and family welfare programmes. The services are provided as an integral unit. Second, as state governments have considerable executive responsibility for implementing various programmes, the demarcation between 'line' and 'staff' functions is much more clearly in the states than the central level.

As in the case of the DGHS at a state directorate of health services similar to a DGHS at the center, also has a director who provides leadership to this team with assistance from additional directors and joint directors. Deans of the state



financed medical colleges and superintendents of large hospitals also report to the director. Director of health services also has officers of the rank of deputy directors and assistant directors to assist him/her in fields like malaria, tuberculosis, leprosy, blindness prevention, extended programme on immunization, hospitals and medical care, nursing, health education, health intelligence, drugs control, prevention of food adulteration medical stores, laboratory services and vaccine production and transport. A senior officer in the directorate performs the line function of overseeing the work of the district health administration, which runs all the health services in rural areas. Health departments of municipalities are responsible for providing preventive and curative health services to urban population.

### **District Health Administration of Tamil Nadu State**

The reorganization of Health and Family Welfare Department took place in Tamil Nadu in 1991. It aimed at integration of the services at all levels. The health programmes in the district are placed under one Joint Director of Health Services. (Refer figure 1.4). He is in the charge of the entire health programme including public health, family welfare, blindness, tuberculosis, leprosy etc.

Figure 1.4

There are two Deputy Directors at district level. One is known as Deputy Director of Medicine, and another is Deputy Director of Rural Health Services. The Joint Director of Health Services and the Deputy Director of Health Services are redesigned as District Medical Officer and District Health Officer respectively for statutory purpose. The District Family welfare, Maternity and Child Health office is called as "district Family Welfare Bureau" and the Joint Director of Health services shall be the head of office (refer G.O.Ms.No. 25, of HIMHFW order dated, 3.1.91).

The programmes through which various functions of health units are implemented in the district are: -

1. Medical care,
2. Control of communicable diseases,
3. Collection of vital statistics - births & death record,
4. Family planning and maternal and child health,
5. Environmental sanitation (including prevention of food adulteration) and
6. School health.

The entire population of district is covered by 12 primary health centers (P.H.C.) and they get line and staff support from the office of the CMO. Besides the PHCs, the office of the CMO also supervises the work of a number of dispensaries of allopathic (about 30-40) and indigenous systems (about 8-12). This organisational set-up brings as to block hospitals.

### **Block Setup of Tamil Nadu**

Two Primary Health Centres (P.H.C) undertakes the health programmes of the block. Two doctors man P.H.Cs; one doctor is made in-charge of the P.H.C. and he is supposed to supervise the entire health programmes of the operational area of the block. While another doctor is supposed to work under the in-charge of the hospital as second in command. It means in the absence of the medical in-charge, the second doctor would look after the duties of the medical in-charge (see figure 1.5). There is a Medical in-charge who is in-charge of the entire health programmes in the operational area. There is a Medical Officer second under Medical Officer in-charge.

Figure 1.5

At the primary health center level, line functions are predominant. The medical officer in-charge provides leadership to other physicians, nurses, laboratory scientists, block extension educators, health assistants and multipurpose workers. He works along with the community population covered under his PHC. In addition to this he is supposed to act as a catalyst for bringing change in the orientation of population.

The above description suggests that administration and organization of health services in Tamil Nadu is divided into 3-tiered structure; state, district and blocks.

Health services are designed to reach out to virtually each of the over 56 million household, located in over 560,000 villages, towns and cities of the country. This task presents a major challenge to health administrators of the country. Increase in the domination of generalist administrators and failure to introduce a proper medical cadre of pan Indian nature have generated the lack of managerial orientation in the contemporary health-administration of India. The virtual absences of managerial physicians who can properly shoulder the new types of responsibilities have become the major obstacles that have affected the proper functioning of delivery system of health care.

Now let us have a look at the delivery system of health care units. Generally the term 'delivery' means conveying or distributing goods and services to a destination. For health delivery we mean hospitals and dispensaries, which come into direct, contact of population and they are supposed to render the services of health care to the masses.

### **Health Care Delivery System**

Health care delivery system is a system in which the services related to health are delivered to the target population. In Health care the higher-level officials do only planning and local staff do the implementation. In India including Tamil

Nadu, the implementing agency of health care programmes is at block level known as Primary Health Centers (P.H.C.). The structure of P.H.C.s is already mentioned in the first section of the Paper (see figure 1.5 for reference). Another Medical Officer assists the Medical officer in-charge of the P.H.C. There is a Block health supervisor who supervises the health activities of the block Hospitals. Under him there happens to be a computer to compute various data, a pharmacist to provide medicines, a Block Extension Educator for propagation of health education through various orientation-training camps. Generally these camps are focused on Information dissemination, health education etc. In addition to this under the Block health supervisor there are three Health Supervisors and five Health Assistants and three Sector Health Nurses. The supervisors and health assistants visit the villages for pathological aids, while the sector health nurses are sent to villages to monitor the activities of Village Health Nurses (V.H.N.). The Village Health Nurses are the lower level staffs that are engaged in the village health units. There are eight health sub-centers attached to one P.H.C. Each Health Sub Center has one V.H.N. The duties of the V.H.N.s are of Pre Natal Care, Post Natal Care, immunization, and taking care of sick population by visiting the villages daily. They have to stay within the Health Sub Centers for all the 24 hours. V.H.N.s are the key functionaries of Health Sub Centres and they have to provide medical help round the clock. 5 trained midwives (dais) from each sub-parts (hamlets) of each village assist a V.H.N. These sub - parts are made only for the health operational purposes.

Since important roles are played by the block and village health officials (Medical Officers, Village Health Nurses, Sector Health Nurses, etc.), it was thought to collect some detailed information on delivery processes from the different levels of health officials and the village respondents. This section is devoted to present the detailed accounts on nature of work, constraints of implementing agencies and respondents opinion on functioning of health bureaucracy of village India.

## **Hierarchical Structure**

It is observed that the organizational set-up of health care organization is hierarchical and it comprises of a centralized system. The delegation of power is not very effective and clear. In the health care delivery organizations, the specializations include, immunization, inoculation, epidemic control, etc., and the officials are given various the assignments to take care of the segmental issues. Each individual pursues his own task without bothering about the total segment of tasks as a whole, as if it was the subject of a sub contract. Consequently, each officer feels that, 'Somebody at the top' is responsible for seeing the entire organizational task decision-making process. The subordinates are not having power to take any decisions regarding plans and programs. Hence, the subordinates always look towards their bosses for some clear cut orders, directions and planning as reported by the Health Officer of P.H.C.s. This suggests that the delivery system is mechanistic and vertical (Burns and Stalker, 1961) in nature. In a mechanistic kind of organization the tasks are broken down into various specializations as is the case of P.H.C.s of Villages A and B. This finding further suggests that the organizational structure of village hospitals is not only mechanistic but rigid too. As we have already discussed elsewhere that the technical methods, duties, and powers attached to each level are precisely written down and are accordingly informed to individual officers of each level for following upon.

There are both merits and demerits of the mechanistic model. For example, in case of the projects related to immunization, family planning etc., this kind of rigidity is needed in work-allocation. Therefore, for such programs this system is a boon. Because of this, Tamil Nadu could achieve 100 percent immunization and could reach to top ranking position. But in case of individual treatment, which varies from location to location, person-to-person one requires to have certain kind of flexibility so that personal attention and personalized care can be given. This cannot be tackled with rigid directions. Therefore, one requires having a balance between rigidity and

flexibility of decisions. There is lack of this kind of balance in the village health organization of the sample population.

1. *Lack of delegation of power:* The health officials informed that for each and every issue of P.H.C.s the decisions are taken in the state health directorate. In those decisions, P.H.C.s members (block and village level) are hardly involved in. This leads to a communication gap between the desired actions and the actual decisions. This leads to either wrong decisions or delayed actions. The Medical Officers of the Kodaikanal and Nilokkottai Blocks and the Village Health Nurses of the Michael Palayam and Periyur Health Sub Centers informed that the centralized power of direction and guidance often leads to inordinate delays. They mentioned that, were areas specific (geographical) have to be tackled by the local official who were conversant with the problems. But generally it was not done and the district level authorities that didn't have proper understanding of the local problems were asked to decide. This invariably leads to serious consequences like death or out break of an epidemic. They informed that village A has different kind of climatic condition. The residents of village A suffer from sickness like Asthma and other cold related sicknesses which was linked with the climatic condition of this village only. No special programme or fund allocation was made to the village A's P.H.C. to keep the disease in control. Consequently, large numbers of residents were suffering from the disease and the village health officials are the spectators. They further suggested that this disease was being ignored because the district level health authorities were not able to comprehend the problem. According to them solution of this lied in the hands of local administration provided the power was transferred to them.

2. *Lack of proper resource allocation based on the individual requirements of vil-lages and P.H.C.s:* The health programmes applicable to local populations are made and imposed by the state health administration. The state health ad ministration lacking real contact with the implementing agencies. Due to lack of intercommunication between the state and decentralized institutions, there exists a gap in allocation of resources. In the present exercise, it was thought

to contact some block level officials who might be helpful in providing with the problems at field level. The Medical Officer informed us that the Primary Health Centres (P.H.C.s) were not able to pay proper attention on health problems of villagers because of the lack of funds. Further, the medical officer informed us that presently the village needed more medicine to take care of gastro-entities, jaundice etc., but they were unable to purchase them since they did not have any fund with them at their disposal. Consequently, the villagers had to face difficulties at the time of crisis.

*3.Lack of equitable distribution of duties and responsibilities:* It was observed that in health administration, that the state authority generally decides the duties and responsibilities of health officials at different levels. They distribute the job based on the inputs available in the district officers. The Medical Officers of the P.H.C.s and the Village Health Nurses of both the villages mentioned that there were unequal distribution of duties and responsibilities. The nurses reported that they were given responsibilities of maintaining the records of births and deaths, immunization, etc., in addition to taking care of patients. On the other hand, the other health staffs, such as, Health Assistants, Health Supervisors and Health Inspectors were given very few responsibilities. They were generally involved in the supervision of different activities. Consequently, the nurses invariably were making complains against the administration for not distributing the responsibilities in an equitable manner. This suggested that the female health staff had more and diverse responsibilities to carry on, while the male staff had fewer duties. Due to the unequal distribution of duties, it was observed that the Village Health Nurses and Sector Health Nurses of sample villages were losing interests in their jobs and were having a feeling of injustice. It is interesting to suggest that this was not a lone case but it was a norm of almost all P.H.C.s.

In the above paragraphs the structure and function of government Health care organization is discussed. However, there are some Non Governmental Organizations engaged in health and family welfare activities in the sample village of our study.

Therefore, it was decided to collect some information on structure and functions of such organizations. Collected information is presented in the following paragraphs.

#### **The structure and functions of Non Governmental Organizations:**

The operation of N.G.O.s was found very different from the governmental health units. Findings suggest that they have lateral relationship between superiors and subordinates. This kind of relationship may be termed as organic organizations.

The organic or organismic structures are flexible in nature (Morgan, Gareth,1988). Organic structures are adapted to unstable conditions, when problems and requirements for action arise which cannot be broken down and distributed among specialist roles within a clearly defined hierarchy. Sickness is a situation, which cannot be predicted, in a specific point of time. It is because of unstable conditions. It varies from person to person, region to region and culture to culture. Because of this, the N.G.O.s follow flexible organic approach to solve such problems. Individuals perform their tasks based on their own skill and training. Jobs lose much of their formal definition in terms of methods, duties and powers, which have to be redefined continuously by interaction with others. Interaction runs laterally as much as vertically; communication between people of different ranks tends to resemble lateral consultation rather than vertical command. The Nurse (N.G.O.s) who stayed in the village attended the cases with her own technical skills with out depending on the orders of the superior body.



Table 1.1: Patterns Of Organization And Management In Governmental And Non Governmental Health Organizations

	GOVERNMENTAL HEALTH ORGANIZATIONS	NON GOVERNMENTAL/ HEALTH ORGANIZATIONS
Nature of Organisation	Relatively stable	Flexible (time to time variation)
Nature of task	Achievement of fixed targets efficiently	Need based
Organization of work	Clearly defined jobs arranged in hierarchical pattern	Jobs defined by individuals concerned through interaction with others
Nature of authority	Clearly defined and vested in formal position of hierarchy; seniority important	Pattern of authority informal and constantly changing as roles become redefined with changing circumstances vested in appropriate skills and abilities
Nature of Communication system	Vertical	Completely free
Nature of Employee commitment	Commitment to own particular jobs	Commitment to central task

**Conclusion:**

Presuming that the nature of hierarchy plays an important part in health bureaucracy the respondents were asked about difficulties arising out of hierarchy in health delivery - processes. From the information made available by the respondents it was revealed that centralised control created problem in dealing with emergency situation. Consequently, respondents did not prefer to go to government hospital if it was a matter of life and death. They felt that by the time help would arrive to them, something unwarranted would happen. To some extent the health officials of the P.H.C.s. supported the respondents' views.

**Procedural devices:**

Different levels of offices have different functional responsibilities but they are supposed to act in coordination. Therefore, coordination becomes the basic ingredient of an efficient bureaucracy. The possibility of reaching to this objective largely depends upon procedural devices. Procedural devices involve information in proper form from the right kind of personnel and speedy action taken on the content of information with proper consultation. Normally, it is presumed that the role of the field information would be very crucial and their information or noting should be the most important device. However, respondents and the village health functionaries informed that things did not happen in this form. The lower officials were the first to record the facts of the case and subsequent actions to be taken on a file. As the files move upward in the hierarchy, the higher officers are free to accept their opinions or take decisions over riding them. More often the higher officials decided and the issue also giving the comments/opinions of the field medical officers. However the field officers (health) reported that sometimes they did require consulting their bosses because of certain doubts about some rules or some clarification sought on certain orders.

To probe further on the issue of decision - making process we asked some questions to health officers and the respondents. Answers presented some fascinating aspects of the decision making process in bureaucratic functioning. The village health officials mentioned that many decisions related to policy issues, instruments to meet the policy requirements fund distribution etc., were dependent upon the nature of cases. In general it was observed that the superior officers had the deciding power on each and every issue. The sense of powerlessness and consequent lack of a sense of responsibility found among the junior health officers apparently affected the overall functioning of the public health - care units and their delivery units as per the opinions of the respondents.

### **References:**

1. Allinson, W. Cristopher, Bureaucratic personality and organisation structure, Hants, Gower Publishing Company, 1984.
2. Anderson, Janes G, and Jay Stephen, Computers and clinical judgments, the role of physician networks, soc sci med, vol.20, no.10, 1985
3. Begur, James w, "A casual model of the health care system: A replication", J.of health and science behaviour, vol.18, 1977 Mar.
4. Bennis, W. and Shepard, H. (1956). A theory of group development. Human Relations 9:415-457.
5. Bennis, W.G. 1968. "Beyond Bureaucracy" Pp. 53-76 in Warren G. Bennis and Philip E. Slater. The Temporary Society. (eds.), New York: Harper and Row.
6. Bennis W. G. Changing Organizations. — In: Management of Change and Conflict, (eds.) Thomas, J M, and Bennis, W. G. Harmonds-woith, Penguin, 1972.
7. Blau, Peter M., The dynamics of bureaucracy, Chicago, The University of Chicago Press, 1969.

8. Blau, P.M. and M.W. Meyer 1971 (2nd. ed.), Bureaucracy in Modern Society. New York: Random House. Meyer, M. W. and Associates. (1978). Environments and Organizations (San Francisco, CA: Jossey-Bass).
9. Blau, Peter M., Orientation toward clients in a public welfare agency, from the book, Bureaucracy and the public, Ed. by Katz and Denet, New York, Basic Books Inc., Publishers, 1973.
10. Bose, Amita- Social impact on chronic diseases: A sociological study of Delhi publication. PhD thesis submitted at I.I.T Delhi.
11. Burns, T., & Stalker, G. M. 1961. The Management of Innovation. London: Tavistock Publications.
12. Camic Charles, The of habit, AJS, Vol.91, No.5 1986.
13. Camp bell, James D, Mauksct Hans, Neikirk Helen J and Hosokama Michael C- Collaborative practice and provider styles of delivering health care, soc sci med, vol.30, 1990.
14. Chan Ho, Suzanne, S.Y, Dietary beliefs in health and illness among a Soc.sci.med, Vol. 20, No.3, pp 223-320,1985.
15. Charmaz,Kathy, Discovering chronic illness using grounded, Soc sci med, Vol.30,1990.
16. Eisenstadt, S.N., Max Weber on Charisma and Institution Building, Chicago, the University of Chicago Press, 1968
17. Gouldner, A. W. (1954). Patterns of industrial bureaucracy. Glencoe, Ill., Free Press.
18. Hall, R. (1982) Organizations: Structure and Processes. Englewood Cliffs, NJ: Prentice Hall .
19. Hall. R. (1982) Organizations: Structure and Processes. Englewood Cliffs, NJ: Prentice Hall.

20. Harrison, I. Michael, *Diagnosing organizations*, California, SAGE Publications, 1987.
21. Heydebrand, Wolf, *Hospital bureaucracy*, New York, Dunellen Publishing Company Inc., 1973.
22. Jones, Michael Owen, Moore, Michael Dane, Synder, C.R., *Inside organizations-Understanding the human dimension*, California SAGE Publications, 1988.
23. Lindblom, C.E. (1968). *The policy-making process*. Englewood Cliffs, NJ: Prentice-Hall.
24. Meyer, John W. and Brian Rowan. (1977). "Institutionalized Organizations: Formal Structure as Myth and Ceremony." *American Journal of Sociology*. 83(2):340-363.
25. Meyer, John W., Francisco O. Ramirez, Richard Rubinson, and John Boli-Bennett. (1977). *The World Educational Revolution, 1950-1970*. *Sociology of Education*, 50 (4): 242-258.
26. Meyer, J. W., & Scott, W. R. (1983). *Organizational Environments: Ritual and Rationality* (Beverly Hills, CA: Sage).
27. Meyer, J. W., Scott, W. R., Strang, D., & Creighton, A. L. (1988). "Bureaucratization Without Centralization: Changes in the Organizational System of U.S. Public Education, 1940-80" (pp.139-167). In L.G. Zucker (Ed), *Institutional Patterns and Organizations: Culture and Environment* (Cambridge, MA: Ballinger).
28. Meyer, J. W., Ramirez, F. O., & Soysal, Y. N. (1992). *World expansion of mass education, 1870-1980*. *Sociology of Education*, 65 (April), pp. 128-149.
29. Nagendra, S.P., *The concept of ritual in modern sociological theory*, New Delhi, the Academic Journals of India, 1971.

30. Negi, Usha, Folk and Modern Medicine in a Hill Village : A Study on Health Knowledge, Beliefs and Practices, Chandigarh, M.Phil Dissertation, Department of Sociology, Punjab University, 1985.
31. Opler, Morris, The cultural Definition of Illness in Village India, Human Organization, Vol.22(1963).
32. Peabody, Robert 1962 'Perceptions of organizational authority: A comparative analysis'. Administrative Science Quarterly 6/4: 463-482.
33. Thani, Nayagam, X.S., Tamil culture and civilization, readings: The classical period, Madras, ASIA Publishing House, 1970.
34. Government move to promote Indian Medicine, A Newspaper Report, New Delhi, The Times of India, dated Aug.7th, 1995.