A STUDY ON HUMAN RESOURCE MANAGEMENT PRACTICES IN PRIVATE HOSPITALS IN KERALA

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BY
RADHA KARUNAKARAN
Reg.No: 1935

Under the Guidance of

Prof. (Dr.) P.Sudarsanan Pillai
Director
Centre for Advanced Studies and
Research in Plantation Management

SCHOOL OF MANAGEMENT STUDIES
COCHIN UNIVERSITY OF SCIENCE AND TECHNOLOGY
COCHIN 682022, KERALA

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DECLARATION

I, **Radha Karunakaran**, hereby declare that this thesis entitled "**A Study on Human Resource Management Practices in Private Hospitals in Kerala**" is a bonafide record of research work done by me under the guidance of **Dr. P Sudarsanan Pillai**, Professor, School of Management Studies and that no part of this thesis has been previously formed the basis for the award of any degree, diploma, associateship, fellowship or other similar title of any other University or Institution.

RADHA KARUNAKARAN

Kochi

Date: 15/05/08

CENTRE FOR ADVANCED STUDIES AND RESEARCH IN PLANTATION MANAGEMENT

Prof. (Dr.) P. SUDARSANAN PILLAI
DIRECTOR
(Dean, Faculty of Social Sciences)

SCHOOL OF MANAGEMENT STUDIES
COCHIN UNIVERSITY OF
SCIENCE AND TECHNOLOGY
KOCHI - 682 022, KERALA, INDIA

No.

Dated : 18.8.2008

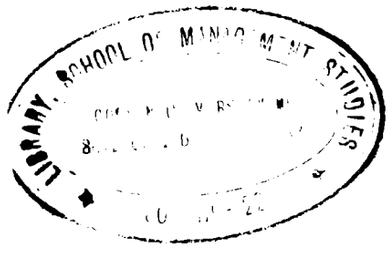
CERTIFICATE

This is to certify that the thesis entitled **"A Study on Human Resource Management Practices in Private Hospitals in Kerala"** submitted by Mrs.Radha Karunakaran to the Cochin University of Science and Technology for the award of the Degree of Doctor of Philosophy is a record of bonafide research carried out by her under my supervision and guidance. The thesis has not previously formed the basis for the award of any degree, diploma, fellowship, associateship or other similar title of any other University or Institution.

Prof. (Dr.) P. SUDARSANAN PILLAI
(Supervising Guide)

Member-Senate, Member-Academic Council, Ex-Director - School of Management Studies, Ex-Head - Department of Commerce, CUSAT
Ex-Dean - Faculty of Commerce, Mahatma Gandhi University, Kottayam
Ex-Dean, Faculty of Commerce & Management, Kannur University, Kannur

✆ : 0484-2575310, 2575096 (Extn: 244), Fax : 0484-2575492, E-mail : pspillai@cusat.ac.in
Res. . No. 5, Type II Quarters, Cochin University Campus, Kochi-682 022, Kerala, Ph. : 0484-2575655



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INTRODUCTION

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CHAPTER 1

INTRODUCTION

India's healthcare sector is making impressive strides into the future by emerging as one of the largest service sectors. According to a joint report of CII-McKinsey (2006), in 2004 national healthcare spending equalled 5.2 per cent of national GDP (Rs.158.20 billion). Healthcare spending in India is estimated to rise by 12 per cent per annum throughout the period 2005-09 (in rupee terms) and scale up to about 5.5 per cent of GDP by 2009.[1] Healthcare in India covers not merely areas of providing medical care, but also all aspects of preventive care. It includes the medical care rendered by the public sector and the initiatives taken by the private sector.

Historically, the Indian commitment to development of healthcare has been guided by two principles (Srinivasan R., 2004) [2]: the first was that, the state is responsible for all healthcare activities and the second, after independence, free medical care to be made for all (not merely to those who are unable to pay). As years pass by, it is being noticed that in India private out-of-pocket expenditure dominates the cost of financing healthcare[3]. Health has become a grave concern for everyone. With the changing demographic and socio-economic profile of the country the public has become more and more conscious about a healthy society. High life expectancy followed by an unprecedented rise in per capita income, and changing lifestyles leading to higher incidence of diseases have led to the demand for increased healthcare. Economic development and higher literacy have increased the demand for quality healthcare services in the country. People are spending more on healthcare

than earlier years and this is bound to increase as projected by Indian Brand Equity Foundation (IBEF).

The Centre for Monitoring Indian Economy (CMIE), Mumbai, estimated the health industry to grow by 13 – 15 per cent by 2006 when compared with 2005[4]. Similarly while the World Health Organisation (WHO) had recommended a bed - population ratio of 1:300 from 2000 onwards, the current ratio is only about 1:1000[5]. So also, the number of hospital beds available in the country is estimated to be around 5.5 million when the actual requirement is nearly 6-6.5 million (Outlook Arena, 2002)[6] and India has about four million people employed in the healthcare sector, which, by 2012, is estimated to go up to 10 million (Robert Kuttner, 2000).

Confederation of Indian Industries (CII) had recognised healthcare sector as an industry in mid-1980s (Outlook Arena, 2002). This industry encompasses various sectors like hospitals, pharmaceuticals, insurance, manpower outsourcing, healthcare tourism, hospital information systems, medical equipments and medical technology.

Hospital is an economic institution with a significant role to play in the community. It is an establishment for temporary occupation by the sick and injured. Economics of hospital sector has often received wide attention; because it has been the major consumer of healthcare expenditure, accounting for about 40-60 per cent in many countries (Varadarajan, Rajeev & Thankappan 2002). It is true even for developing countries, where the health system is often hospital-dominated (Mills A., 1990) [7]. India is not different from others since the budgetary allocations of different states are often accused of being pro-hospital (World Bank, 1995) [8].

In this connection the definitions of a hospital becomes relevant.

Hospital in Steadman's Medical Dictionary is "an institution for the care, cure and treatment of the sick and wounded, for the study of diseases and for the training of doctors and nurses"[9].

Dorland's Illustrated Medical Dictionary defines a hospital as "an institution suitably located, constructed, organised, staffed to supply scientifically, economically, efficiently and unhindered, all or any recognised part of the complex requirements for the prevention, diagnosis and treatment of physical, mental and medical aspects of social ills; with functioning facilities for training new workers in many special professional, technical and economic fields, essential to the discharge of its proper functions, and with adequate contacts with physicians, other hospitals, medical schools and all accredited health agencies engaged in the better health programme"[10].

According to the Directory of Hospitals in India, (1988), a hospital is "an institution which is operated for a medical, surgical and /or obstetrical care of in-patients and which is treated as a hospital by the Central/State Government/local body or licensed by the appropriate authority"[11].

Thus delivery of good healthcare is the basic activity of a hospital. It is an area of concern of the Central/State Government, local body or the appropriate authority because healthy people make a healthy nation. In India, health, and particularly hospitals, have always featured in all the budgets and Five-Year Plans.

1.1 STATEMENT OF THE PROBLEM

India, being the second most populous country in the world, has many limitations in reaching out to the entire population especially on healthcare and

education. 'Sub-optimal functioning' of the public healthcare system is identified as a major impediment in the process of healthcare system development in India (Kunhikannan T. P. & Aravindan K.P.)[12] Lack of hospitals, laboratories, equipments, drugs, qualified doctors, staff and their poor attitude towards patients have resulted in tarnishing the image of public hospitals. As a result, utilisation of government healthcare units including Primary Health Care Centers (PHCs) is abysmally low. Even among the low income group only about 30-40 per cent seek medical help from the PHCs. This low utilisation of facilities has resulted in underutilisation of manpower. Further, the non-salary component in government health expenditure is also diminishing fast over the last few years.

Expenditure for healthcare is being incurred by the State Governments, either from their own resources or with funds from the Central Government and externally aided projects. Fiscal crisis in various states has forced governments to reduce the budget allocation for healthcare. Further, the meagre amount collected from patients for availing medical facilities at government hospitals does not cover even a fraction of the actual cost involved in providing the service.

After the introduction of the New Economic Policy in June 1991, Government hospitals are facing the problem of resource crunch since the overall allocation to healthcare per se has come down (Ramaswamy K. & Renforth W.)[13] The diminishing role of the State has already brought down the share of government spending in healthcare from about 25 per cent in 1991 to 17 per cent in 2001 (National Health Policy, 2002)[14].

There exists a wide gap between the facility requirements and staffing due to the reduction in government spending on healthcare. This gap can be bridged only by allocating more funds, which apparently is not possible for reasons explained elsewhere.

However, the expectation of the public about the infrastructure and supporting services for healthcare has not diminished. The wide gap between the expectations of the public and the reality is currently being bridged by services provided by the private sector. This has however resulted in commercialisation of healthcare, high healthcare costs and denial of services to many.

The private sector now plays a dominant role in India's healthcare delivery system. The factors such as the Economic Policy of 1991, influx of modern medical technology, growing deficits of public sector hospitals and rising affluence of middle class have contributed to the large scale growth of hospitals in the private sector in the last few decades. However, this growth has got its own consequences. Private health services are costly and often ignore the quality factor. There is no serious effort to regulate the private sector, so that it can be used as an effective means of delivering healthcare (Bhat Ramesh, 1999) [16].

Kerala is unique with respect to healthcare and education. With the advancement of science and technology and access to modern medicines and medical technology, utilization of healthcare facilities has increased tremendously among the urban population. This has led to an increase in the number of private hospitals in the State over the past decades. Kerala has the maximum number of private hospitals and beds.[18]

Kerala's allopathic healthcare infrastructure includes 5654 institutions and 1,15,792 beds. When there are only 1,317 (23.3%) hospitals that are owned by the State, there are around 4,288 hospitals in the private sector[20]. Public sector commands control over 23 per cent of institutions, 39.5 per cent of beds and 13.6 per cent of doctors only, whereas 76 per cent of institutions, 58 per cent of beds and 85.7 per cent of the doctors are in the private sector. The remaining 0.3 per cent institutions, 2.2 per cent beds and 0.7 per cent doctors are in the co-operative sector (Table 1.1). The number of beds in Government institutions grew from 36,000 to only 38,000 during the decade 1986 –1996, and the number of private hospital beds grew from 49,000 to 67,500 during the same period (Ramankutty V., 1999)[23]. In the Government sector there are over five lakh trained doctors, seven lakh auxiliary nurses and mid-wives (ANMs) and anganwadi workers besides community volunteers.

Table 1.1

Number of Allopathic Hospitals and Beds in Kerala, 2000*

Sector	Number	Per 100,000 Population	Beds	Per 100,000 Population
Public Sector	1,317 (23.3)	4.14	45,684 (39.5)	143.48
Private Sector*	4,288 (75.8)	13.47	67,517 (58.3)	212.06
Co-operative Sector	49 (0.9)	0.15	2,591 (2.2)	8.14
Total	**5,654 (36.9)♣**	**17.76**	**1,15,792 (94.2)**	**363.68**

* Figures concerning the private sector correspond to the year 1995.

♣ Figures in parentheses are the percentages.

Source: Government of Kerala (2002)and Economic Review 2001,Thiruvananthapuram, State Planning Board, pp.134-140.[21,22]

The above statistics reveals a situation where opportunities are more in hospitals in the private sector. The scaling employment opportunities lure many doctors, nurses and para-medical staff to join the private sector. But, as there is minimal government control over the private hospitals, the hospital authorities get away with various policies on salary, welfare benefits and even legislative compliances. Further, the dismal working conditions and quality of staff employed by private hospitals in Kerala have been debated in many fora. This is a very critical issue which needs to be looked into and researched at length.

1.2 RELEVANCE OF THE STUDY

Higher organisational effectiveness, machines, technologies, procedures and systems are no doubt important; but what is more important is the quality of the individuals behind them. Managing the human assets in any organisation, be it hospitals or otherwise, is a far more difficult proposition than managing the other physical and financial aspects. All organisations, whether big or small, manufacturing or service-oriented, profit or non-profit making, are basically human organisations. Hospitals or healthcare institutions are not different from this and are very much dependent on their human resource. Managing qualified human resource is a key to success and healthcare, as a labour-intensive sector, is bereft with problems. Human resource plays a significant role in the effective performance of a hospital. This depends to a great extent on the quality of its staff – the better their quality, the higher the level of performance.

A study of 'Human Resource Management' (HRM) in an organization assumes importance in this context.

According to Decenzo and Robbins (1989), "Human Resource Management is concerned with people's dimension in management. Since every organization is made up of people, acquiring their services, developing their skills, motivating them to higher levels of performance and ensuring that they continue to maintain their commitment to the organization are essential to achieving organizational objectives. This is true, regardless of the type of organisation--government, business, education, health, recreation or social action"[24].

A hospital deals with life, suffering, recovery and death of human beings. For the right direction and running of such an institution its administrative personnel needs a particular combination of knowledge, understanding, traits, abilities and skills. The role of nurses and para-medical staff in a hospital assumes still greater importance since they interact more with patients. So it is imperative that they be motivated and their satisfaction level enhanced. Often the behaviour of personnel is cited as one of the major reasons for the poor perception of healthcare services (Lee, 2001). This perception is more prevalent about public sector hospitals and is more so in the rural areas. This drives the rural population to seek treatment from the traditional healers or postpone treatment or even approach the urban private hospitals (Maheshwari & Bhatt)[25].

Many studies conducted on nurses reveal their dissatisfaction with staffing pattern. They are overloaded with different types of works, majority of which are non-nursing in nature. They also lack supportive, stimulating, challenging or

encouraging environment to work (B.T.Basavanthappa, 2003)[26]. Attrition rate is very high in the hospitals, especially with the foreign labour market eyeing the English-speaking nurses of Kerala. Even when everything is not known about the working conditions or labour practices in other countries, the salaries have always lured many qualified doctors and nurses.

In the Government hospitals there are many welfare schemes and provisions of leave for doctors and nurses. A Government health worker is given salary by the government and revisions are made from time to time. Over and above this, they have various allowances like uniform allowance, washing allowance, leave encashment and the like. But vacancies are not filled as and when they arise and fresh recruitments are not made annually. Therefore, after graduation, many nurses join the private hospitals in Kerala.

There is no government body to check on the system of payment or human resource management practices prevalent in the private hospitals. Since this is an unorganised sector the dismissals are neither questioned, nor overtime remunerated. Eight hours' norm recommended by the Nursing Council of India is never complied with. Though they work along with doctors, nurses and para-medical staff get less recognition and even less pay than they deserve.[27]

There is hardly any career plan or systematic evaluation done by the hospitals. The bed - nurse ratio of 3:1, as stipulated by the Nursing Council of India, is replaced by giving the responsibility of up to 15-20 beds. Many of the employees are kept either as temporary or as bonded staff, so that there is less financial burden on the

hospital. Unlike other organizational structures, hospitals follow matrix structure, where the staff, including doctors, report to more than one superior.

The nursing and para-medical staff have a different human resource policy altogether. Even though the Bhore Committee has specified on the minimum employee requirement on the basis of bed capacity, in reality it is hardly implemented. Since many hospitals have some nursing college/school, which offers courses like Auxiliary Nursing and Midwifery (ANM) and General Nursing and Midwifery (GNM) attached to them, the hospitals make use of the services of such students even without paying them.

Healthcare is a process involving constant interaction with patients. As such the hospital employees are actually sensitive to the working conditions and morale, and this ultimately affects the quality of service provided by them. So they should be trained, evaluated, counselled and paid well.

International Healthcare Consultants Kurt Salmon Associates (KSA)[28] conducted an All-India study in 2000 by an in-depth understanding of the various change agents to understand the direction the health industry is likely to move during the next decade. KSA's "Health Outlook", as the study was called, identified areas such as length of stay, organizational issues and service mix as the most important issues of concern in this area. The factor of organizational issues of the study touched upon areas like pay, career advancement, job security, working hours and work culture. Thirty per cent of the employees surveyed said that pay was the major criterion for employment.

KSA analysis based on 80 international hospitals suggested that one of the keys to success of hospitals is their effective human resource management in getting productive outputs from their medical and non-medical professionals. The study concludes that if the hospitals spend at least 10 per cent more on employees (including doctors) than the present, there would be a minimum of 50 per cent more efficiency in their output (Anil Rajpal & Sachin Kaushik, 2002)[29].

People are the source of all productive efforts in an organisation. Organisational performance depends upon individual performance. If the efforts of every single individual are coordinated and directed towards the realisation of well-established objectives the synergy so achieved would definitely transcend to the sum total of individual performance or even more. Based on the perception that people are the central resource in any organisation and in any society, if proper thrust is provided to the growth and betterment of employees towards higher levels of capability it would help bring greater productivity and higher satisfaction.

A systematic study of HR practices in private hospitals of Kerala in this context is expected to be of great help to policy makers in formulating guidelines for human resource management in hospitals. It would also be useful to the HR managers in the effective implementation of various HR policies in the private hospital industry which will increase the productivity and satisfaction of the employees and benefit the management, which eventually will work to the advantage of the end-users – the society as a whole.

1.3 OBJECTIVES OF THE STUDY

The overall objective of the study is to assess the effectiveness of human resource management practices in private hospitals in Kerala State. The specific objectives of the study are:

1. To investigate into the different Human Resource Management practices in private hospitals, particularly focusing on the problems, limitations and effectiveness of these practices.
2. To identify the reasons for the high rate of employee turnover in the private hospitals in Kerala.
3. To examine whether factors influencing human resource management differ with hospitals under different managements.
4. To examine how working environment can be improved and a favourable work culture introduced in private hospitals.
5. To draw some conclusions and make recommendations for the effective human resource management practices in private hospitals in Kerala.

1.4 METHODOLOGY

1.4.1 Sampling Design

The private allopathic hospitals in Kerala are under different types of management, run by individuals or organisations. Most of them come under the organisational set-up like corporate, Christian missionaries or churches, private trusts, or societies like Nair Service Society (NSS) and Sree Narayana Dharma Paripalana

Yogam (SNDP). They are of different sizes in terms of number of beds or doctors and other paramedical staff.

For the purpose of this study the private hospitals are classified according to the number of beds and only those hospitals with 100 or more beds with at least five year's standing were considered for the study as (i) these bigger hospitals naturally have a greater number of employees and therefore are more appropriate for a study of human resource management practices and (ii) any hospital takes a minimum five year's time to settle down in their human resource management practices.

There are such 147 private allopathic hospitals with more than five year standing and 100 or more beds. A district-wise break-up of the number of such private allopathic hospitals of Kerala is given in Table 1.2:

Table No. 1.2

District-wise Classification of Medical Institutions According to Bed Strength

Sl.No	District	100 – 199 beds	200 beds and above	Total
1	Kasargod	4	1	5
2	Kannur	7	5	12
3	Wayanad	5	0	5
4	Kozhikode	2	3	5
5	Malappuram	2	2	4
6	Palakkad	5	1	6
7	Thrissur	10	9	19
8	Ernakulam	10	13	23
9	Idukki	11	6	17
10	Kottayam	7	5	12
11	Alappuzha	2	2	4
12	Pathanamthitta	6	5	11
13	Kollam	3	5	8
14	Thiruvananthapuram	9	7	16
State		**83**	**64**	**147**

Source: Report on Medical Institutions in Kerala – 2004, State Planning Board, Kerala.

The districts with more number of hospitals in order are Ernakulam (23), Thrissur (19), Idukki (17), Thiruvananthapuram (16), Kottayam (12), Kannur (12), Pathanamthitta (11) and Kollam(8). All the other districts have less than 8 hospitals. We confined our study to these districts with higher number of hospitals. Since Kottayam and Kannur have 12 hospitals each, we decided to consider only Kottayam

district, leaving Kannur for geographical continuity of the study. The study was thus confined to the seven districts namely Ernakulam, Thrissur, Idukki, Thiruvananthapuram, Kottayam, Pathanamthitta and Kollam having a total of 106 hospitals. These 106 hospitals were categorised into three on the basis of their management type: Corporate, Mission-run and Societies or Trusts. Thus a multi-staged random sampling was conducted and the number of hospitals selected under each category is given in Table 1.3:

Table 1.3

Nature of Ownership of Private Hospitals in Kerala Undertaken for study

Type of Ownership	No. & %
Corporate	10 (21.75)
Mission-run	15 (32.60)
Societies/Trusts	21 (45.65)
Total	**46 (100)**

Source: Field Survey

1.4.2. Sources of Data

The study is based mainly on primary data collected from the 46 randomly selected private hospitals, with the help of questionnaire/schedule prepared for this purpose and information collected through interviews with the management and employees of selected hospitals. The survey focused on both the top management and the employees in the non-managerial cadre. The interview with the top

management was carried at to understand the human resource management policies and practices prevalent in their respective hospitals using an interview schedule. The copy of the schedule is included in Annexure I.

The employees in the non-managerial cadre were covered to know the type of human resource climate existing in their respective hospitals. Also focus group discussions were conducted first among doctors, nurses, para-medical staff and administrative staff and then with matrons and ward nurses to identify the factors affecting work environment and their work. A copy of the questionnaire is included in Annexure II.

The schedule and questionnaire were developed after a proper review of literature on human resource management practices in Indian and global perspectives. The questionnaire was administered to 308 clinical and non-clinical staff who tried to identify the level of human resource climate existing in their hospitals.

The interview schedule and questionnaire were pre-tested in three hospitals in Kottayam. Based on the response, suitable modifications were incorporated and the schedule was administered in 46 hospitals selected at random in Kerala from eight districts. Repeated visits were required in most of the cases.

Further, the general information required was obtained from secondary sources. Secondary sources include the publications from the Indian Society of Health Administrators (ISHA), World Health Reports (WHO) and various study reports of the State Planning Board, Department of Economics and Statistics and Directorate of Health. Data were collected from the various consultancy and research associations of colleges like Administrative Staff College of India (ASCI), Centre for Development

Studies (CDS) Thiruvananthapuram, Apollo Hospitals, Hyderabad, Mahatma Gandhi University, Kottayam and C.Achutha Menon Memorial Library, Thiruvananthapuram.

1.4.3. Tools of Analysis

The following statistical tools are employed for the analysis of data:

Simple statistical tools like percentages and correlation have been used for the first level analysis,

Analysis of Variance (ANOVA) is applied and F-ratios are calculated out to find out whether there is any significant difference in the responses of managers under different ownerships.

Factor analysis of Variance is done to test the overall significance of each of the factors of recruitment in the private hospital as a whole. Principal component method was applied for the same. 'Z' test was also done to find out whether there is any significant difference in the opinion of the respondents.

1.5 SCHEME OF THE STUDY

CHAPTER 1: Introduction: It gives a brief introduction along with the statement of the problem, significance of the study, objectives to be examined, methodology adopted, sources of data, limitations and scheme of chapterisation.

CHAPTER 2: Earlier studies on Hospital Management: A review. It deals with literature survey pertaining to the topic of the study in the Indian and global scenario.

CHAPTER 3: Development of Healthcare Sector in India: This chapter explains in detail about hospitals – their origin, health status of Kerala, public health spending by state governments in India, budget and health and healthcare infrastructure of Kerala.

CHAPTER 4: Management of Private Hospitals – An Overview: Management of private hospitals with specific emphasis on various functional areas of management including human resource management is explained in this chapter. It includes definition and significance of human resource management, human resource climate, hospital information system etc. It also includes scope and structure of a human resource department and the functions of a human resource manager.

CHAPTER 5: Human Resource Management Practices in Private Hospitals in Kerala. This chapter is dedicated for the analysis of the interview schedule given to the hospital administrators/directors on various HR issues like manpower planning, recruitment and selection, training, promotion, transfer, performance appraisal, compensation, communication networks and industrial relations.

CHAPTER 6: Employees' Perception on Human Resource Management Practices in Private Hospitals in Kerala: An analysis. This chapter deals with the analysis of the questionnaire given to employees (doctors, nurses and para-medical staff), to assess whether there exists a conducive work environment in their respective hospitals.

CHAPTER 7: Summary and Conclusions. Based on the earlier chapters, relevant findings and recommendations are made in this chapter. This chapter also presents the conclusions emerging from the study.

1.6 LIMITATIONS

Any study is bereft with problems and limitations. The basic limitation of the study is:

The unwillingness on the part of the management of various hospitals to furnish details with respect to employee details. Since human resource is a sensitive issue, many management representatives were reluctant to divulge information. This delayed the whole process of data collection since repeated visits were compulsory for almost all the cases.

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Chapter II

EARLIER STUDIES ON HOSPITAL MANAGEMENT: A REVIEW

CONTENTS

CHAPTER II

EARLIER STUDIES ON HOSPITAL MANAGEMENT: A REVIEW

2.1 INTERNATIONAL STUDIES ON HOSPITAL MANAGEMENT

Though studies on the financial aspects of government hospitals and their break-up, hospital waste management, quality control and hospital management systems are available in plenty, only few studies have been undertaken from human resource perspective in the private sector. Even international studies talk basically about restructuring, cost analysis and quality assessment in hospitals.

The 1992 Vol. (a) of International Labor Organization (ILO) has very specifically mentioned about the absence of published studies in the field of health. "In many countries until recently, there has been little interesting employment practices in the health sector and this is reflected in the absence of published studies in this field."[1]

One of the criticisms about research on hospital performance as reported by Elizabeth West in 'Management matters: the link between hospital organization and quality of patient care' is that "it has been rather insular, paying little attention to developments in the related fields such as Organizational Sociology, Organizational Behaviour, Management Studies, or Human Resource Management. Most of these disciplines study organizational performance in the context of a market and their dependent variables are usually profitability, productivity or market share."[2]

The resolutions drafted by Ashtekar started with the following note: "India belongs to the bottom layer of the Human Development Index (HDI) in the world. Within the country, barring Kerala and Goa, most states show poor health indicators."[3]

In a country where services are centralised, with an imbalance in personnel and low staff motivation and poor standards of care, there will be a resistance to any new reform. There has been a decline in the standards of service between 1986 and 1997. Poor financial and human resources policies and management are resulting in high cost and poor quality of care. A recent study concluded: "Human resources should become the central focus for reform". [4]

World Bank has provided a clear understanding to every country on health and its importance. It has also criticized the approach of various governments on public health. "A population's health contributes to its well-being directly, because health is necessary to the enjoyment of life, and indirectly, because healthy workers are more productive. Because people appreciate both the consumption value and the production value of their own health, even poor households spend surprisingly large amount of their own resources for healthcare, and people lobby their governments to provide subsidized healthcare. Yet analyses of health sector spending in poor countries find that governments typically spend too little money on health with too little result."[5]

The same point of lack of government support for healthcare has been reiterated through Richard G.A. Feachem's study which says, "In Asia, and especially in India, health care is mainly purchased 'out of pocket' from private doctors and clinics. In many African countries, the proportion of finance and provision that is

private is rising due to the reality and the perception (which has lagged behind the reality) of the inability or unwillingness of governments to pay for and provide even basic health services to the majority of the population. The governments of low-income and middle-income countries, together with the international agencies and the health policy community, have neglected or ignored this reality over the past decades. It can no longer be avoided."[6]

But, in the meeting on the follow-up of World Health Assembly Resolution WHA 48.8 and the recommendations of the Ministerial Consultation on Medical Education and Health Services it was reported that "Health personnel generally account for 60–70% of total ministry of health budgets."[7]

Jishnu Das and Jaffrey Hammer, in their article in Journal of Development Economics, explain public sector spending on healthcare and the items under which the money is distributed. "The public sector spends more than 80% of the government's health budget on salaries for doctors and heavy subsidies to educate them."[8]

Research and Consultancy Outsourcing Services, that offers complete business reports about various industries, have envisaged a major growth in healthcare. Their November 2006 report states "Healthcare industry is the world's largest industry with total revenues of approximately US$ 2.8 Trillion (2005)."[9]

William Glasser (1972), while comparing hospitals in different countries, comments that "Medical institutions cannot originate without a market. Anthropological evidences suggest that recognition of physical and emotional problems by potential patients is universal among the world's population, whether he

is a western city dweller or a peasant in an underdeveloped country. The human being is aware of discomfort and inability to perform his normal social roles. However, the decision to take practical action and the choice of remedies vary widely according to the social system and the individual status in each social system".[10]

The report on discussion at the Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms at Geneva in 1998 declared that "Health services are usually seen as 'essential services' and so health workers have the legal status of public servants. They are accountable to employers and professional bodies and subject to strict regulation and registration rules. Nowadays, the public health sector is changing from being a public service to one with a greater commercial focus. The same Health Assembly adopted a resolution (resolution WHA 48.8) urging the World Health Organization (WHO) and its member states to undertake coordinated reform in health care, focusing on making better use of resources, especially human resources. This recommendation applies not only to the utilization of health care workers but also to their education and training."[11]

Stephen Bech in his article "Labour and social dimensions of privatization and restructuring: Healthcare Services", asserts various issues of human resource management in private hospitals. Some of the excerpts on the topic which he submitted to the International Labour Officer are as follows:

"The health sector has evolved a complex division of labour with a high degree of specialization. In response to the budgetary constraints and the difficulties of recruiting certain types of occupational groups, managers are reorganizing and

reform in healthcare, focusing on making better use of resources, especially human resources. This recommendation applied not only to the utilization of healthcare workers, but also to their education and training.[13]

Saltman and von Otter (1995) in their article, "Implementing planned markets in healthcare: Balancing social and economic responsibility", explains that, "It is probably no exaggeration to claim that flexibility in the use of labour and in payment system is one of the most sought after effects of the entire health reform process". [14]

Berman Peter in his article, 'Health sector reform: making health development sustainable' considers health sector reform and its impact on Human Resources for Health (HRH) in developing countries and countries in transition. Health sector reform has been defined as the "sustained purposeful change to improve the efficiency, equity and effectiveness of the health sector". Health sector reform involves many fundamental changes to the way in which public services are financed, organised and delivered in both the developing and the developed countries, and often operates as part of a wider programme of public sector reform. Fiscal reform, the introduction of market mechanisms and decentralisation are the three key elements of health sector reform.[15]

Jane Lethbridge, in her publication on human resources for health entitled, 'Public Sector reform and demand for human resources for health', stated, "Although health sector reform has included elements of human resources strategies such as improved education and training, restructured salary scales and a closer link between performance and reward, it has also had a fundamental impact on organisational

culture and public sector ethos, which, in turn, influence demand for human resources". [16]

The quality of medical services depends on the competence of providers, the incentives for them to show up for work, and the allocation of resources within clinics.[17]

Abel Smith, B. (1983), is of the opinion that "In-patient care seemed to consume just under half of all the expenditure on health services. In the USA and Sweden it was higher – about 45% but generally, most of the current hospital expenditure is for staff".[18]

A study of four countries in Eastern and Southern Africa by Mogedal S. and Steen S.H. concluded that "human resource development, personnel management and staff motivation are critical issues. Tanzania, although it has invested in human resource development, found that low salaries, delayed promotion opportunities and poor working conditions led to dissatisfaction in the workforce. Staff performance has been found to be unsatisfactory. Although monetary and non-monetary allowances were supposed to compensate for low wages, they have led to poor teamwork and lack of continuity in health service operations". [19]

While studying the influence of health sector reform and external assistance Burkina Faso, Bodart C., Servais G., Mohamed Y.L. and Schmidt B. reported, "In a country where services are centralised, with an imbalance in personnel and low staff motivation and poor standards of care, there is resistance to the new reform. There has been a decline in standards of service between 1986 and 1997. Poor financial and

human resources policies and management are resulting in high cost and poor quality of care. Human resources should become the central focus for reform". [20]

Studies by Peter I. Buerhans forecasted a significant shortage of registered nurses over the next 10 years; because anywhere in the globe the number of nurses leaving the labour market will exceed the number of new entrants, thereby resulting in demand outpacing supply. [21]

Franco L.M., Bennett S. and Kanfer R., in their study on public sector health workers' motivation, reiterate that "Low pay also contributes to low administrative capacity, as well as poor organisational discipline. In an analysis of health worker motivation, health sector reform was found to influence health worker motivation through changing organisational structures and community-client roles. Organisational factors influence worker motivation through management structures, communication processes, organisational support structures, processes, and ways of providing feedback about organisational and individual performance". [22]

On the basis of the study conducted by Alwan A. and Hornby P., it has been proved beyond doubt that "the working conditions of health workers need to be improved. This might be achieved through developing more flexible employment arrangements that are employee-focussed. The public sector needs to be encouraged to establish a "living wage" and other forms of worker security, so that terms and conditions of public sector workers are better than those of private sector workers. Health workers need to have access to continuous professional development that includes skills for performance management, management of contracts and other new ways of operating in reformed systems". [23]

Peter Bernam (1986), in his article on cost analysis as a management tool for improving the efficiency of primary care, gives some examples from Java and Indonesia, showing as to how the inefficiencies in staffing patterns, personnel management and drug management can affect cost efficiency. He found that routine analysis of cost data could provide the basis for management incentives to local health units to increase both output and quality of care.[24]

According to Brito, Galin and Novick, "In the public institutions that remain, market conditions have been introduced and services are contracted out, which has resulted in a widespread decrease in job security in many countries. Health workers have moved from collective-bargaining arrangements to individual contracts. Decentralisation and privatisation have contributed to the breakdown of national collective bargaining. In Eastern and Central Europe, new organisations and professional associations and reorganised trade unions have led to a breakdown in labour relations expertise.[25]

Wheelan Susan's study on teamwork and patient's outcome in intensive care units brings links between teamwork and positive outcomes that have been established in a number of fields. Investigations of a similar nature in healthcare yielded equivocal results. Staff members of units with mortality rates that were lower than predicted, perceived their teams as functioning at higher stages of group development. They perceived their team members as less dependent and more trusting than did staff members of units with mortality rates that were higher than predicted. Staff members of high performing units also perceived their teams as more structured and organized than did staff members of lower performing units.

The study tends to support the contention that, while motivation and commitment remained high, morale among nursing staff was often low. The reasons varied, but included heavy workloads, exacerbated in some instances by staff shortages and the amount of change taking place. A frequent complaint made by staff is about a lack of promotion opportunities, or doing work out of grade because of reducing the numbers of high-end graded posts.

While different methods of working, new technology, etc., lead to greater productivity, it also leads to increased staff workloads. Staff said that they were caring for more patients with fewer staff; that many staff had to cover up absences with no extra resource; and that there was often an unnecessarily long gap between a post becoming vacant and it being filled. There were concerns that quality of treatment was suffering and a fear that reducing manpower may finance future pay awards. Long working hours and heavy workloads contribute work place stress and ill health. Many times even over time have exceeded statutory regulations.[26]

Organisational factors influence worker motivation through management structures and processes, communication processes, organizational support structures and processes, and ways of providing feedback about organizational and individual performance. These changes in organizational culture have often had a negative impact on workers' motivation. Important informal factors, for example staff commitment, have 'become the prime means of direction, motivation, coordination and control'. When staff commitment deteriorates over time, health workers may migrate, not only from public sector to private sector but even

internationally. This results in the shortage of skilled health workers within the public sector, precipitating in the growing demand for skilled health workers.[27]

Del Favero A. and Barro G. comment on Italian Health Market as "These managers are usually not medically trained and this may create tensions with the medical staff who feel threatened by the increasing power of managers. Doctors fear that their professional autonomy is being undermined as a budgetary logic overrides the needs of patient care. This process has been particularly marked in countries, which have introduced forms of managed competition. In the UK, general managers were introduced in the mid-1980s. These managers on short-term contracts linked to performance-related pay had strong incentives to meet their budgetary targets. The 1990 reforms, which introduced competition between hospitals, have strengthened further the position of managers to the dismay of the nursing and medical professions. In Italy, the 1995 health reforms introduced elements of managed competition and decentralized authority more to hospital level, reinforcing the position of hospital managers". [28]

Himalayan Times, a daily of Nepal, states in detail a few hospital regulations they propose in the article 'Nepal hospital regulations: Can we have an update?' In July 2002 the Nepal Government announced plans to regulate health services to be made effective from January 2003. This was announced at a workshop organised by the Ministry of Health in Kathmandu on 'Review of criteria for private health institutions in Nepal'. The guidelines laid down include the following:

(i) Medical Professionals would not be allowed to work at more than two institutions. (ii) Private hospitals and nursing homes would have to provide facilities

for emergency, outpatient and surgery services, among others. (iii) Hospitals with over 100 beds would have to have a blood bank. (iv) Charges against the hospital / doctor would be determined by a committee formed by the government. (v) Hospitals to conform to salary standards set by government.[29]

Gary Starzynski comments on a survey, which was conducted on 19 Central New England Laboratories, that some hospitals had positions available, but unfilled because it was difficult to find qualified personnel. Most hospitals said technical employees stay at their institutions for two to five years. Salary considerations were the leading reason given for employee departures, but few laboratory managers anticipated major changes in their salary structure over the next five years. Overtime was cited as the chief method of coping with staffing shortages. On asked as to why technical workers stay on the job longer than clerical workers, they said, 'Perhaps they feel a stronger need to gain more experience before moving on.'

When the participants were asked to identify the four most common reasons that Medical Technicians and Medical Lab Technicians leave the profession, more than three-quarters cited money (salary dissatisfaction or an opportunity to earn more). Stress or burnout and hours were also factors, according to two-thirds of the respondents. Eight respondents (44 per cent) mentioned frustration with the profession; only seven (39 per cent) mentioned fear of AIDS and other communicable diseases.[30]

Polidano, in his article, "The New Public Management in Developing Countries – in Public Policy and Management" suggests that, low pay levels have led

to staff leaving the public sector and moving to the private sector, NGOs and aid agencies.[31]

Low pay also contributes to low administrative capacity, as well as poor organisational discipline. In an analysis of health worker motivation, health sector reform was found to influence health worker motivation through changing organisational structures and community-client roles. Organisational factors influence worker motivation through management structures and processes, communication processes, organisational support structures and processes, and ways of providing feedback about organisational and individual performance.[32]

Studies on nurse burnout and magnet hospitals [Magnet status is an award given by the American Nurses' Credentialing Center (ANCC), an affiliate of the American Nurses Association, to hospitals that satisfy a set of criteria designed to measure the strength and quality of nursing.] in the United States concluded that professional development, cooperation with medical staff and managerial support were highly important for nurses.[33]

These changes in organisational culture have often had a negative impact on workers' motivation. Important informal factors – for example, staff commitment – have "become the prime means of direction, motivation, coordination and control". When staff commitment deteriorates over time, health workers may migrate, not only from the public sector to the private sector, but internationally. This results in a shortage of skilled health workers within the public sector, precipitating a growing demand for skilled health workers. [34]

The working conditions of health workers need to be improved. This might be achieved through developing more flexible employment arrangements that are employee-focussed. The public sector needs to be encouraged to establish a "living wage" and other forms of worker security so that terms and conditions of public sector workers are better than those of private sector workers. Health workers need to have access to continuous professional development that includes skills for performance management, management of contracts and other new ways of operating in reformed systems.[35]

Barnsley, Louise et al. in their article, 'Integrating learning into integrated delivery systems' tries to promote the fact that thorough learning and flexible hospital personnel would be better prepared to face the challenges imposed by a complex and competitive environment. The integration of learning into these systems requires a shared vision, facilitative leadership, and highly functioning communication channels within an organic structure. Strategies that promote positive attitudes toward change are necessary for learning as is the provision of resources, training, incentives, and rewards that support learning, and feedback on how new administrative and clinical practices advance the mission and goals of the system.[36] Therefore, hospital resource information system must be set up. The system's first challenge would be to create a "climate" that encourages people from diverse parts of the system to interact in ways that develop common understandings and trust.[37]

McGourty, Tarshis, and Dominick describe several integrative management practices that contribute to an innovative culture by encouraging collaborative behaviour, informal relationships, constructive conflict, cross-functional

communication, and open communication with external sources. These practices include: "(a) employee rewards and recognition; (b) employee development; and (c) multifunctional teams. Reward programs that link performance reviews and decisions on career progression and promotions to successful learning reinforce the value that the system places on the generation of new knowledge and insights. Knowledge acquisition and transfer can be supported through employee development activities, such as on-the-job training, job rotation, and training programs that emphasize teamwork, interpersonal skills, idea generation techniques, and management of the innovation process. New ideas can be stimulated by encouraging the regular review and debate of ideas and by making discretionary funds available for experimentation. Finally, multifunctional teams can be used to bring together a variety of specialists and customers in order to generate a broad knowledge base for the cross-fertilization of ideas".[38]

Education and training programs can be powerful tools for transferring knowledge and skills across system components if they are linked explicitly to use. Employees who have opportunities to practise what they have learned, and whose posttraining performance is monitored, are the most likely to master new knowledge and skills.[39]

Integrating information technology (IT) into medical settings is considered essential for transforming hospitals into 21st century health care institutions. An article reported a 3-round Delphi panel that tried to analyse problem that personnel experienced with electronic data systems. In round 1, 35 administrative, clinical, and IT personnel answered 10 open-ended questions about IT strategies and structures that

best support successful transformation. Four domains emerged from round 1: IT organization, IT performance monitoring, user-support activities and core IT responsibilities (e.g., computer security, training).

Performance monitoring and clinical support activities were rated as the most important, and organization and core IT responsibilities were rated as relatively less important.[40]

Even when a study was conducted in Australia to identify the factors affecting job stress and job satisfaction of Australian nurses it was identified that a significant challenge facing the healthcare sector was the recruitment and retention of nurses. The job stress and job satisfaction of nurses have been associated with recruitment and retention. The aim of this study by Timothy and Theresa was to consider two factors that may contribute to the job satisfaction and job stress of nurses: social support and empowerment. Using a sample of 157 registered nurses in a private hospital in Melbourne, Australia, they found that "social support derived from the nurses supervisor and work colleagues lowered job stress and at the same time increased job satisfaction. The presence of nurse empowerment, meaning, impact, competence and self-determination, also lowered job stress and increased job satisfaction."[41]

2.2 STUDIES ON HOSPITAL MANAGEMENT IN INDIA

Modern society has developed formal institutions for patient care. The hospital, a major social institution, offers considerable advantages to both the patients and the society. A number of health problems require intensive medical treatment and personal care, which normally cannot be available in a patient's home or in the clinic of a doctor. This is possible only in a hospital where large number of professionally and technically skilled people apply their knowledge and skill with the help of world class expertise, advanced sophisticated equipments and appliances.[42]

Most of the studies in India too have been about managing finance or the social issues related to health. In Health, Poverty and Development in India (Das, Chen and Krishnan) [43] the authors have mentioned about the health statistics and poverty ratios of developing India. Social issues have been focussed in the article 'Social Intermediation and Health Changes: Lessons from Kerala' (Kabir M. & Krishnan T.N.) [44] and in 'Historical Analysis of the Development of Health Care Facilities in Kerala State' (Kutty V.R.)[45], where the authors try to explain the revolutions happening in the health sector. Ramachandran V.K[46] has also analyzed Kerala's health in his article 'On Kerala's Development Achievements - Selected Regional Perspectives'. Over and above these social perspectives a few financial perspectives can also be seen as in 'Managing Money of Hospitals' (Jangaiah P.). Again studies on quality has made its presence, thanks to the multidimensional, generic, internationally used market research instrument called SERVQUAL (Parasuram et al., 1988). [47] The human resource aspects have been studied only on a limited scale, even though we have huge medical professionals.

While inaugurating an eleven-day seminar on 'Hospital Management' in the All India Institute of Medical Sciences, Dr. S.S. Sidhu, the then Secretary, Ministry of Health and Family Welfare, admitted:

Management was the weakest aspect of Indian hospitals and called for their management by professionally trained personnel, especially because a hospital is a labour-intensive organization and employs a very large number of people. Such a labour-intensive organization needs a highly proficient management. He reiterated that modern hospitals need not only highly qualified medical specialists, para-medical and nursing officers but also personnel managers, finance officers, cost accountants, housekeeping officers, linen and laundry officers, food service managers, maintenance managers, security officers, etc. He further said that apart from the rising population which has increased the pressure on hospitals, society has now accepted the hospital as a healthcare institution and is utilizing it more frequently, often for even minor ailments. The ever rising demand increases the need for proper management of hospitals.[52]

Studies by the Central Bureau of Health Intelligence show the following: majority of Indians trust private healthcare even though its average cost is more than US$4.3 and the government–owned healthcare agencies cost only US$2.7. It has further been estimated that while 59 per cent of healthcare expenditure originated from the 'self-paid' category, less than 30 per cent is contributed by the states. The study also reports 'limited government investment provides significant opportunities for private healthcare service providers as large investments are required to scale up the country's healthcare infrastructure. The government is likely to meet only 15-20

per cent investment in hospital beds, assuming it increases expenditures by 6-7 per cent from the current base. Assuming 10 -15 per cent commitment from international donors, there would be a shortfall of 70 per cent, which would definitely be funded by private companies.[53]

'At a time when the expenditure requirements on health are rising, the State is finding it increasingly difficult to meet these requirements. In fact, the quality of services in the Government health services has declined for want of enough funds.

Consequently, there has been an increase in the demand for private medical care services offered very often on commercial terms. "This, in turn, has boosted the average private expenditure on medical care. The State seems to be losing its gains on the health front," K.K George, Director of Centre for Socio-Economic Research said. [54]

According to the study by IBEF, on the Indian Healthcare sector, 'The Indian healthcare sector has been growing at a frenetic pace in the past few years. The windfall began ever since the developed world discovered that it could get quality service for less than half the price.

India will spend US$ 45.76 billion on healthcare in the next five years as the country, on an economic upsurge, is witnessing changes in its demographic profile accompanied with lifestyle diseases and increasing medical expenses, says a CII-Mckinsey study on 'Health in India'. Revenues from the healthcare sector account for 5.2 per cent of the GDP and it employs over 4 million people. By 2012, revenues can reach 6.5 to 7.2 per cent of GDP and direct and indirect employment can double, it said.

Private healthcare will continue to be the largest component in 2012 and is likely to double to US$ 35.7 billion. Other estimates suggest that by 2012, healthcare spending could contribute 8 per cent of GDP and employ around 9 million people.

From a pan-India perspective, presently there are more than half a million doctors employed in 15,097 hospitals. Additionally there are 0.75 million nurses, who look after more than 870,000 hospital beds. During the previous decade, the number of doctors has increased by 36.6 per cent. An estimated 30 per cent of medical practitioners hold specialist qualifications.[55]

Soumya Viswanathan (2002), in her article on Outsourcing in Healthcare Management, opines that " Employee per bed ratio can be kept optimum, provided effective utilisation of manpower is done by creating multi-skilled and multi-tasked personnel. In a typical hospital set up, expenditure on salary amounts to roughly 25-30 per cent of total income or 30-35 per cent of total expenditure. This is not healthy statistics, say experts. Most hospitals are believed to operate with excess manpower. As competition increases and margins come under pressure, hospitals tomorrow will have no option but to rationalise manpower, which, in other words, would mean downsizing." [56]

Ravi Duggal (2000), in a symposium on the state of our Public Health System, stated, "Today there are over 15,000 hospitals (68% private) with about 900,000 hospital beds (45% private), about 25,000 primary health centers in the country, and a total of over 12,00,000 qualified practitioners (89% private) of all systems of medicine. The skewed rural/urban availability of public health services is well known – 70% hospitals and 85% of hospital beds under the public domain are located in

urban/metropolitan areas, while 70% of the population lives in the rural and backward areas of the country.

The pattern of distribution of the private health services is not very different. They too tend to concentrate in urban/metropolitan areas – 60% of hospitals, 75% of hospital beds and 70% of allopathic doctors are found in urban areas. However, the private health sector is not confined just to quality allopathic practitioners. There are nearly twice as many practitioners qualified in various Indian systems of medicine and homoeopathy, and a larger proportion of them (60%) are located in the rural and backward areas, 90% of them also practising modern medicine.

Over the last nine Five-year plan periods the Planning Commission, or for that matter, the Ministry of Health have not paid much heed to the way in which the private health sector has grown and operated. In fact, the state has subsidised the growth of the private health sector by various means – subsidised medical education even for those who ultimately go into private practice or, worse still, migrate abroad; concessions, subsidies and tax relief to private practitioners and hospitals. Many private hospitals function as trust hospitals whose incomes are exempt from income tax. Public sector units have supplied bulk drugs and raw materials at subsidised prices to the private pharmaceutical industry and have in the process earned the label of 'being in the red' and 'inefficient' .Import duty concessions for expensive new medical technology which largely benefits the richer sections have also been provided". [57]

A Study of Hyderabad and Chennai hospitals by Rama V. Baru, Brijesh Purohit and David Daniel (1999) states "We feel privatisation has influenced the perception and practice of the medical professional."[58]

Rita Dutta (2003), in her article 'Nurses come and nurses go, but hospitals learn to survive', mentions about the exodus of nurses. 'Today when patient satisfaction is accorded supreme importance with the healthcare sector functioning like any other service industry, one of the thrust areas of a hospital is good nursing care. However, providing good nursing care today poses the biggest challenge with hospitals grappling with the alarming exodus of nurses.

On an average a private hospital in a metropolis witnesses an annual exodus of around 50 nurses, with some hospitals even facing an outflow of over 80 nurses, annually. Hospital administrators complain that no sooner a fresh nursing student learns the ropes of her job she is lured away by the lucre in hospitals abroad. The domino effect is that a lot of constructive time of nursing administration goes away in screening new candidates to fill up the vacancy'.[59]

Wilfred A. D'Souza (1982), Minister of Health, Goa, Daman & Diu spoke on training for medical professionals as extremely important since obsolescence in this area is very quick. The health workers have to constantly update their skills, knowledge and attitudes.[60]

B.S. Aggarwal in his article, 'Hospital Profits Depend on its Relation with the Doctor', stresses on the material benefits a hospital can earn by maintaining a good relationship with the doctors. He says, "If the doctors are happy they would

recommend the hospital facilities to a large number of patients and consequently a profitable hospital is established.

In his opinion, doctors should be awarded bonuses out of hospital profits. The bonus should be on performance basis. This currently creates loyalty to the hospital project and a sense of belonging comes in all doctors when they get his or her due share.

A teamwork is more appropriate to establish a good rapport with the public and it promotes the good functioning of a speciality. Moreover a good teamwork is essential to run the hospital emergency turn by turn or unit by unit.

The nursing and other staff are migratory birds and one can stop them only through good payment for good work while keeping the minimum commitment notes for their probation period and experience gained."[61]

'Service quality in Bangalore hospitals – an empirical study' was conducted by R.Rohini and B.Mahadevappa,[62] to identify five dimensions of service quality, the most important being, assurance of quality of nursing care in five major hospitals in Bangalore. It was brought to the notice of the researchers that most of the in-patients were extremely happy to the excellent nursing care, assistance in the reception, neat and clean house keeping facility, very cordial and empathetic staff, ever-smiling and ever-ready helpers and the attitudes of the physicians who would listen to their queries sympathetically.

Gajendra Singh et.al., [63] had identified customer satisfaction as one of the critical success factors in his article 'Potential of healthcare industry in India'.

N.V. Ramamurthy's article proposes certain suggestions to Nursing Schools and Colleges. Entitled, 'Training the Angels' he comments that "Manpower drain to developed economies is a constant worry and, in the case of nurses, especially of late, this should not be taken lightly. The industry has to find ways and means of retaining talent and not remain content with the claim that a populous country will always provide cheap manpower. Quality of healthcare does suffer in the long run. The industry should invest in setting up reputed nursing colleges primarily for domestic requirements and later for overseas demand, if required, but experienced staff must be given their due in this country first."[64]

Rues Ajita Pawar, Nursing Superintendent, Nanavati hospital, Mumbai, states, "Nursing is a skilled job which requires training. The various courses in nursing sadly do not give an understanding of clinical care. It is only during the job that they learn. But by the time they gain experience, it is good bye time for them." [65]

C. M. Francis (1998) opines that "Health is labour intensive and an area where trained manpower is most critical. If the health care is to improve it is necessary that a concerted effort be made to make available the right kind of personnel in the right number at the right places. Problems of inadequate numbers, improper training and unequal distribution have to be solved." [66]

Following are the resolutions adopted and reiterated in the Council Meeting of Trained Nurses Association of India (TNAI), (2003) on "Recruitment of nurses on contract with less salary",

- Whereas it is observed that nurses are recruited on contractual basis on lesser salary in many Government and private hospitals, which is not in keeping with the human rights of equality.
- Whereas it is observed that there is no uniformity in pay scales of nurses within a particular institution/state, while they perform similar jobs.
- Be it resolved to urge the Central and State Governments, Municipal Corporations and other employing authorities to recruit nurses on regular basis and not on contractual basis.
- Whereas it has been brought to the notice of the Trained Nurses' Association of India, that there are unqualified and unlicensed persons working as nurses in different parts of the country by obtaining false Nursing Certificate through illegal means.
- Whereas it is felt that if these unscrupulous persons are allowed to function without proper scrutiny, the patient care system will be in jeopardy and Whereas the Trained Nurses' Association of India, Indian Nursing Council, State Nursing Councils, Central and the State Governments should take suitable legal action against such persons.
- Be it resolved therefore, that the unqualified and unlicensed persons who are working as nurses in different institutions in various parts of the country by obtaining false certificates should be traced and suitable legal action taken by the authorities concerned.[67]

Janpaksh, a revolutionary magazine brings to notice that "After the nurses themselves saw that nothing can be achieved without building pressure upon the Government, they took to strike on 5th May 1998, demanding implementation of new pay package, enhancement in allowances, time bound promotions, proper housing, filling up of vacancies, setting up of Nursing Directorate, non - practising allowance and implementation of 1997 agreement.

Nurses have learnt the valuable lesson that whatever concessions the working people can get, they can get only through their united and concerted efforts and only by taking to the path of struggle. Nobody is going to pay heed to their plight, unless and until the working people themselves do not rise up against the conditions of their life and once the working people rise to change these unjust conditions, no power on this earth would be able to prevent them from achieving their common goal i.e. Liberation of the working people."[68]

Another magazine, Amar Jesani, also wrote about nurses in the private sector as " Interestingly, most nurses' strikes have been in the government sector, though in India the private sector holds an estimated three-fourth of hospitals and beds. The private sector must employ at least as many nurses as the government does, if not more. And their condition is much worse."[69]

Hindustan Times Bureau reported in September 2003 on Code of Ethics for hospitals in Andhra Pradesh, "Private nursing homes and hospitals in Hyderabad will now have to follow a Code of Ethics requiring them to standardise their rates, make their billing transparent, counsel patients and follow clear procedures for diagnosis and treatment. The code is to be followed by all the 450 institutions registered under

the Andhra Pradesh Private Hospitals and Nursing Homes Association's Hyderabad and Rangareddy district branch.[70]

Ms.Saritha Varma in her article in the Financial Express stated, "At Rs 11.54, the fund-strapped Kerala exchequer's spending per patient is also the highest in the country. However, a recent study by A Raman Kutty has observed that although the state's inputs in health care have not fallen, 98 per cent of this went to feed establishment costs, like wages. However, over 20 million poor patients in taluk hospitals and medical college wards still go without beds, medicines and care."[71]

Francis P.A., comments in his article, 'An Excellent Legislation', about the revolutionary legislation which could bring regulatory control on private hospitals, nursing homes and other healthcare establishments. He comments "The private sector plays a crucial role in the healthcare sector of this country today as most of the state governments have failed to set up adequate number of hospitals and primary health centres. The mushrooming growth of private medical facilities in states, therefore, is only a natural outcome of the states' neglect of this social responsibility. Most of the states do not even have proper records of the number of private medical facilities operating. A large majority of these private medical establishments do not follow any standards of services as there are no specific regulations to govern them. They, therefore, indulge in several unethical practices and charge exorbitant fee for the substandard services."[72]

On commenting on recruitment of different categories of staff in JNM Hospital, Cochin, Dr. P.K.Puryakayastha, Chief Medical Officer, Fertilizers and

Chemicals Travancore Ltd., Kerala said "written job assignment is served to the concerned employee within 4 weeks of order of appointment." [73]

He suggests that the following broad general principles should, therefore, be kept in view in organizing the health services of tomorrow:

- The training of the health services personnel should be fully oriented to the people – their social, cultural and economic conditions and their health profile.
- The health services should be pyramidically organized – with a large base in primary healthcare and a narrow top in the specialized and highly specialized institutions.
- The preventive, promotive and curative problems should be defined accurately at each level, right from the village to the sub-center, community, district, State and Central levels. This should be on the basis of actual studies and not on assumptions as at present.
- The skills, services and facilities required for each level must be defined on the basis of the above findings.
- The selection of personnel and their training should be on the basis of the requirements for the specific jobs they have to perform. The education level for the selection of candidates must be adequate and not excessive. Over-education is often counter-productive.
- Selection at the lower levels should be of persons from within the local community itself.

- The service conditions should be properly defined and more equitable than at present. There should be adequate avenues for promotion of all workers on the basis of ability and motivation. Transfers should not be misused, as is often done at present, for purposes of punishment or harassment.
- Training should be as close to workers as possible. It should be job specific, decentralized, efficient and economic.[73]

Indian Journal of Medical Ethics (Oct-Dec 2004) reports, "Nurses' abysmal wages and working conditions have not been affected by the many national level committees on the subject".[74]

Rita Dutta,[75] reports in The Indian Express, that "The exodus is markedly low, if not non-existent, in the corporate hospitals because of better salary and training. Wockhardt Hospitals Group, for instance, does not witness less than five nurses leaving their hospital, annually. Vishal Bali, Vice President, Wockhardt Hospitals Group, states that they are able to retain their nurses as they offer better salary and training on par with international standards.

Saritha Varma reported in Financial Express that "Vacant posts in government hospitals are not being filled up and the nurse-patient ratio is pretty skewed, says a nursing college staff. In general wards of government hospitals it should be 1:6. "But it goes up to 1:30. And then patients expect nurses to be pleasant and smiling. Is it possible?" she asks. Nurses therefore prefer private hospitals even though they pay less — a stop-gap arrangement before they go abroad."[76]

Ravi Duggal, health researcher and activist stated, "The spread of private clinics and hospitals must be regulated through a strict locational policy, wherein the

local authority is given the right to determine the number of doctors or hospital beds they need in their area (norms for family practice, practitioner : population and bed ratio, population ratios, fiscal incentives for remote and under served areas and strong disincentives and higher taxes for urban and over served areas etc., can be used).

Duggal, also suggested that Continuing Medical Education (CME) should become compulsory and linked to renewal of registration. Graduates passing out of public medical schools must put in compulsory public service of at least five years, of which three years must be at PHCs and rural hospitals. This should be assured not through bonds or payments, but by providing only a provisional licence to do supervised practice in state health care institutions and also by giving the right to pursue postgraduate studies to only those who have completed their three years of rural medical service". [77]

Varadarajan in his article in Journal of Health & Population in Developing Countries has compared health status of Kerala with Tamil Nadu. He states,

"Although Tamil Nadu is comparable with Kerala in terms of several human development indicators (some experts even predict that the State might overtake Kerala in about 20 years or so from now), 'Kerala model of development' still remains unique and it is difficult to replicate it elsewhere. The similarity between Tamil Nadu and Kerala ends with their achievements in the fields of health and education. Otherwise, there are a lot of dissimilarities between them including the paths chosen by the two States to achieve what they achieved so far. High literacy, equitable development, strong political system, healthy life style and a well functioning public (Allopathic and *Ayurvedic*) health care system have all contributed

to the attainment of good health indicators in Kerala. In contrast, Tamil Nadu had poor literacy, high degree of poverty and inequitable development with serious rural-urban, rich-poor and male-female differences when the health indicators started showing up. But, Tamil Nadu had better economic growth indicators. One factor that was common between the two States was a well functioning public health care system."[78]

And finally in his address to the members of the Kerala Legislative Assembly, Dr.APJ Abdul Kalam, the President of India, said "Nursing is a core competence of Kerala. India is in the process of improving the healthcare services which will need additional 5 lakh nurses. As per the latest report, worldwide requirement for nurses are estimated to be around one million from now to 2012. Presently, in India about 50,000 nurses qualify every year. There is a need to increase this capacity to 2 lakhs within the next five years in the country. The present contribution of 4,000 nurses from Kerala State should also increase at least 20,000 nurses per year. In addition there must be a special drive to equip the nurses with training at various healthcare centers and super speciality environments and equip them with language skills and proficiencies that can match the required international standards. Kerala can definitely cater to at least 50% of the total demand i.e. provision of one million nurses from now to the year 2012. The Department of Health in Kerala should draw up a scheme and embark on an intensive nursing training scheme in collaboration with the Central Government which will enable generation of quality health care professionals at the rate of 2 lakh nurses per year. In addition, with increasing complexity of healthcare profession with diagnostic equipment, tele-medicine, clinical trials etc. There is a

need for many other specialized paramedical personnel. Skilled technicians and the para medical assistance are in great demand world over in the healthcare sector. The tremendous potential exists for educated youth to take up nursing and para-medics as a profession. The generation of quality nurses can be taken as one of missions for the development of healthcare services in Kerala without sacrificing quality."[79]

Thus the survey of literature on human resource management issues brought to light the existence of research gaps in studies in the private hospital segment in Kerala. This study is expected to reduce the gap on the various HR issues related to human resource in the private hospital sector of Kerala which basically include (a) a detailed study of the existing human resource management practices and (b) identifying the reasons for the high rate of employee turnover in the private hospitals in Kerala.

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Chapter III

DEVELOPMENT OF HEALTHCARE SECTOR IN INDIA

CONTENTS

CHAPTER III

DEVELOPMENT OF HEALTHCARE SECTOR IN INDIA

INTRODUCTION

In India healthcare is delivered by both the public and the private sectors. The public healthcare system consists of healthcare facilities run by Central and State Governments which provide services free of cost or at a subsidized rate to the low income group in rural and urban areas. With the Indian economy enjoying a steady growth, the industry is heading towards growth phase. In India, 80% of the healthcare expenditure is borne by the patients and that borne by the state is 12%. The expenditure covered by insurance claims is 8%.

3.1 MARKET SIZE OF HEALTHCARE SECTOR IN INDIA

The Indian healthcare sector constitutes:

- Medical care providers: physicians, specialist clinics, nursing homes and hospitals
- Diagnostic service centres and pathology laboratories
- Medical equipment manufacturers
- Contract Research Organizations (CROs), pharmaceutical manufacturers and
- Third party support service providers (catering, laundry).

The Indo-Italian Chamber of Commerce, in its report in 2007, stated that 'The healthcare industry is expected to increase in size from its current € 12.72 billion to € 29.6 billion by 2012. India will spend € 33.8 billion on healthcare in the next five

years as the country, on an economic upsurge, is witnessing changes in its demographic profile accompanied with lifestyle diseases and increasing medical expenses. Revenues from the healthcare sector account for 5.2 per cent of the GDP and it employs over 4 million people. By 2012, revenues can reach 6.5 to 7.2 per cent of GDP and direct and indirect employment can double, it said. Private healthcare will continue to be the largest component in 2012 and is likely to double to € 26.41 billion. It could rise by an additional € 6.5 billion if health insurance cover is extended to the rich and middle class. Coupled with the expected increase in the pharmaceutical sector, the total healthcare market in the country could increase to € 39.22 – 54 billion (6.2-8.5 per cent of GDP) in the next five years.'[1]

As such, the healthcare sector revolves around hospitals and related services. A hospital is a healthcare organisation and is defined by the World Health Organisation as "an integral part of the medical and social organisation which is to provide for the population complete health care, both curative and preventive; and whose outpatient services reach out into the family in its home environment. The hospital is also a centre for the training of health workers, and for bio-social research."[2] A hospital consists of service facilities for out-patients, in-patients, general wards, emergency, special wards, Intensive Care Units (ICU), operation theatres, delivery suites and support services like pharmacy, radiology and imaging, central sterilizing, blood bank, laboratory, etc. Besides curative and preventive care, hospitals also have a third service, namely palliative care – the care of the terminally ill till their death. Thus management of hospitals is a complex task as the WHO document says,' Hospital is a complex organisation'. [3]

3.2 GROWTH OF HOSPITALS IN INDIA

Hospitals in India have existed from ancient times. Even in the sixth century B.C, during the time of Buddha there was a number of hospitals to look after the crippled and poor. The Buddhist devotees started more hospitals in different parts of India. The outstanding hospitals in India at that time were those built by King Asoka (273 - 232 B.C). Charaka and Shushrutha – the father of surgery – of ancient India were famous physicians in those days. Medicine based on Indian system was taught in universities of Taxilla and Nalanda, which contributed to the advances in Arabic medicine. 2600 years ago Sushrutha and health scientists of his time conducted surgeries like caesareans, cataract, fractures and urinary stones. Usage of anastasia was well known in ancient India. Even the 'upakalpa - niyam adhyayam' of Charaka and Sushrutha gave specifications for hospital buildings, labour rooms and children's wards.

The qualifications for hospital attendants and nurses as well as specification for hospital equipments, utensils, instruments and diets have also been given in these great books. From the books written by Arabian and European travellers, the study of medicine in India was in the bloom. Every major city had a medical school. The decline of Indian medicine started with the invasion of other countries in the tenth century AD. The invaders brought with them their physicians called "hakims".

They started to prosper at the expense of vaidhyas. The use of allopathic system of medicine commenced in the 16^{th} century with the arrival of European missionaries to South India. It was during the British rule that there was progress in the building of hospitals. The first hospital in India was built in Goa, as mentioned

in Fryeis Travels. The Portuguese developed hospital of the European type at Calicut, Goa and Santhoru (Chennai) through missionary organisations. They set up treatment centres and trained local men and women as dressers, nurses etc.

In 17th century, European doctors employed by the East India Company played an important role in the introduction of modern medicine. Medical care based on this system spread all over India. Organized medical training was started in the 19th century. The first medical school was started in Calcutta where modern and ayurvedic systems of medicine were taught.

Since the planned healthcare programmes in 1951, India has emerged as a leader in the healthcare delivery field. This has been made possible as a result of the planning process, national health and medical education policies and implementation of the recommendations of several committees.

India today has the largest number of medical colleges, is the number one country in export of medical, nursing, and paramedical personnel, has the largest infrastructure from central level to periphery levels with approximately 2.2 lakhs institutions and over eight lakh bed capacity; has the largest number of pharmaceutical organizations and capacity and know-how to manufacture all kinds of drugs, medical and hospital equipment.[4]

3.3 GROWTH OF HEALTHCARE SYSTEM IN KERALA

Kerala has a long history of organized healthcare. The private health sector – both indigenous and western systems of medicine has played a crucial role in the overall development of the state. The Ayurvedic system of medicine practised in Kerala dates back to centuries handing down their traditions from generation to generation. When colonial powers established their presence here, they brought their medical care system with them. In the 19th century the princely rulers of the erstwhile States of Travancore and Cochin took the initiative in making the western system of medical care available to all. To add to this, missionary hospitals contributed profusely by even going into the interiors of the State and providing medical care. It is believed that one of the first hospitals in India was established by Portuguese settlers in old Malabar during the 16th century. The public health intervention of the Rockefeller Foundation, a major 'philanthropic' organization of the 20th century especially in early Travancore remains even to this day as the foundation of institutionalization of health.

The first major public health intervention in Travancore as in rest of India was vaccination against smallpox in 1860. The first census of hospitals conducted in 1928 revealed that Travancore had 30 hospitals, 38 dispensaries, 18 grant-in-aid medical institutions and 14 mission hospitals that dispensed western medical care. The number of allopathic hospitals and healthcare centres began to multiply rapidly in Travancore and Cochin since the 1930s.

The foundation stone for the first medical college of Kerala was laid by Rockefeller Foundation in 1951 in Central Travancore. Thus by the time the State was

formed in 1956, the foundation for a sound medical system accessible to all citizens was already laid. Development of health services cannot be confined to the provision of preventive care alone – the general hospitals in Cochin and Trivandrum are about 150 years old. Opportunities for employment in medical care institutions increased over the years. The number of patients treated in hospitals and dispensaries doubled between 1951 and 1961. By the 1970s, Kerala's medical facilities showed the highest rate of use in India.[5]

Table 3.1 shows system-wise details of private medical institutions of Kerala. With respect to allopathic system of medicine, there has always been an increase in the number of hospitals as against Ayurveda.

Table 3.1

System-wise Details of Private Medical Institutions in Kerala

Sl.No	System of Medicine	Year		
		1986	1995	2004
		No.	No (%)	No. (%)
1	Allopathy	3565	4288 (+20.28)	4825 (+12.5)
2	Ayurveda	3925	4922 (+25.40)	4332 (-11.98)
3	Homeo	2078	3118 (+50.05)	3226 (+ 3.4)
4	Others	95	290 (+205.26)	535 + 84.48
Total		**9663**	**12618 (+30.58)**	**12918 (+2.38)**

Source: Report on Survey of Private Medical Institutions in Kerala – 2004, Department of Economics and Statistics, Thiruvananthapuram

Traditionally the non-government sector has been very active in Kerala State as can be seen from Table 3.1. For a long time, they all belonged to the non-profit making category sponsored by various medical missions. But of late commercial health institutions in the private sector are mushrooming with profit as the chief motive. Probably they are exploiting the gaps and deficiencies in the government coverage. While the Government sector accounted for 53.32% of the institutions and 58.82% of the beds in 1976, the same sector accounted only for 22. 5% of the institutions and 36.32% of the beds in 1995. It is interesting to note that 66% of the private institutions are in rural areas accounting for 53% of the beds and 49% of the doctors. However, all the private hospitals focus on the curative medicine rather than preventive medicine.[6]

3.4 HEALTH STATUS OF KERALA

In spite of the economic backwardness, Kerala has made remarkable achievements in health almost comparable with that of even developed nations. The widely accepted health indicators like crude death rate, infant mortality rate, and life expectancy are evidences of this (Table 3.2). Kerala's achievements are very high when compared to other major Indian states in areas like birth rate, death rate, Infant Mortality Rate (IMR), average life at birth and immunization. Birth rate in Kerala is 17.3, death rate is 6.6 and infant mortality is 11. But All India birth rate is 25.4, death rate is 8.4 and IMR is 66. The overall population growth rate of about nine per thousand during the census decade 1991-2001 indicates that Kerala is on the track to achieve zero population growth quite soon. Average life at birth in Kerala is 73 years,

whereas it is 68 years for the country. Kerala achieved good health status even with low growth in income and high unemployment rate.

Table 3.2

Health Status of Kerala

Indicators	Kerala	India	USA
Crude Death Rate	6.6	8.4	7
Infant Mortality Rate	11	66	8
Crude Birth Rate	17.3	25.4	17

(Sources: 1. Health Services Data, Govt. of Kerala, 1996;

2. World Health Report WHO, Geneva 2002).

This acclaimed position of Kerala when compared to All – India or the USA is an outcome of 'Kerala Model of Health', which was characterised by good health at low cost. The state had made a strong commitment to health services provision and the government's budgetary allocation to health was considerable during the period from mid fifties to early eighties. The annual compounded growth rate of government healthcare expenditure for the period was 13.04 per cent [7]. Coupled with initiatives by the government on health, education to all was also very well accepted by the people. As such every woman was educated and they in turn took a positive outlook towards health by consulting qualified doctors only instead of quacks or traditional healers on any matter of health.

3.5 PECULIARITIES OF THE KERALA SITUATION

In Kerala private sector plays a very significant role in imparting health to the public. Many analysts talk about a unique 'Kerala Model of Health' giving way to

American Model of Healthcare. The hallmarks of Kerala model were low cost of healthcare and its universal accessibility and availability even to the poorer sections of the society. There are certain characteristics of the Kerala situation, which are pertinent to the health sector. They are:

3.5.1 A good portion of the health infrastructure in Kerala was created long time ago and there is an urgent need for rehabilitation and upgradation. At this point of time, when the finances are weak, this is a serious concern for there is a real danger of rapid deterioration.

3.5.2 The changing demographic profile with the number of old people on the increase has several implications for the provision of healthcare. It has also to be noted that a good number of old people may not be able to pay for their healthcare.

3.5.3 The changing epidemiological scenario in the state with increase in lifestyle diseases like cardio-vascular disease, diabetes and cancer also calls for adjustment in the provision of healthcare.

3.5.4 A literate and aware population of the state long used to availing of hospital's services has a tendency to visit hospitals even for minor ailments. This has increased the number of non-series patients in the secondary and tertiary hospitals consuming considerable share of professional time. Also because of this tendency many people tend to bypass lower level facilities and rush to the territory hospitals in the hope of getting better care and thereby place an avoidable burden on these facilities.

3.6 HEALTHCARE FACILITIES IN KERALA

As per Article 47 of the Constitution of India it is the duty of the state to raise the level of nutrition and standard of living of its people and the improvement of public health as among the primary responsibility. In tasking the State to raise the standard of living of the people and to improve the public health, the Constitution views that it is the duty of the State to create a good environment for the living condition of its citizens.[8]

The physical environment in most parts of Kerala is conducive to health, and Kerala has made commendable achievements in health standards though there are certain instances of viral attacks like Chicken guinea, rat fever, etc. The factors contributing to such unique situation was a wide network of health infrastructure, manpower, policies of the State Government etc and other social factors like women's education, general health awareness and clean health habits of the people.[9] Health needs of Kerala as in other states of India are catered to by joint participation from the state government, private hospitals and cooperative sectors.

The government hospitals come under the purview of health and family welfare department and the structure is as follows: [10]

3.6.1 Government Health Infrastructure

The State Department of Health and Family Welfare under the Minister for Health, guides and supervises the Health and Family Welfare programmes in the state. The Secretary and Additional Secretary to the Government, Health and Family Welfare Department have overall responsibility in administration and programme implementation. The Allopathic system has three major wings, viz. Directorate of

Health Services, Directorate of Medical Education and Directorate of ESI Medical services which are under the labour department. In addition to modern medicine, there are two Directorates of indigenous medicines, viz. Ayurveda and Homeopathy.

3.6.1.1 Directorate of Health Services

At the State level the programmes on Health and Family Welfare are implemented, supervised and co-coordinated by the Director of Health Services. The various programmes are looked after by Additional Director of Health Services, who is assisted either by Deputy Directors of Health Services or Assistant Directors of Health Services.

3.6.1.2 District

At the district level District Medical Officer of Health in the rank of Deputy Director of Health Services (and Additional Director of Health Services in three Corporations) is in charge of all the health and family welfare activities. The DMOs are assisted by Deputy DMOs in the cadre of ADHS (and Dy.DHS in the three Corporations) and other technical and ministerial staff.

3.6.1.3 Peripheral Institutions

At the end of March 2000 there were 1317 Government Medical institutions in the state with a total bed strength of 45684. Of these, 143 are Hospitals (including MCHs), 944 are PHCs, 105 are CHCs and 89 are Dispensaries, besides 21 T.B Centre / Clinic and 15 Leprosy Control Units.

Primary Health Centres (PHCs) are the cornerstones of rural healthcare; the first part of an effective referral system. It forms the first level of contact and a link

between individuals and the national health system bringing healthcare delivery as close as possible to where people live and work.

Each PHC is targeted to cover a population of approximately 25,000 and is charged with providing promotive, preventive, curative and rehabilitative care. This implies offering a wide range of services such as health education, promotion of nutrition, basic sanitation, provision of mother and child family welfare services, immunisation, disease control and appropriate treatment for illness and injury. The PHCs are hubs for 5-6 sub-centres that cover 3-4 villages and are operated by an Auxiliary Nurse Midwife (ANM). These facilities are part of the three-tier healthcare system; the PHCs act as referral centres for the Community Health Centres (CHCs) and 30-bed hospitals and higher order public hospitals at the taluk and district levels.

The government health infrastructure is given in Table 3.3.

Table 3.3

Government Health Infrastructure in Kerala

Institutions	2000		2001		2002	
	No:	Beds	No:	Beds	No:	Beds
Hospitals	143	31819	143	31933	143	31905
Community Health Centres	105	4202	105	4415	107	4503
Primary Health Centres	944	5009	943	5215	994	5166
Dispensaries	53	164	54	176	54	186
T.B Centres/ Clinics	21	268	21	240	21	228
Leprosy Control units	15	-	15	-	15	-
Total Allopathic Medical institutions	1281	41462	1281	41979	1281	41988

Economic Review 2002, State Planning Board

It may be noted from Table 3.3 that though there is practically no increase in the number of government hospitals over the period 2000-02, there is a slight increase in bed strength. Over the years bed strength in allopathic government hospitals increased from around 13,000 in 1960-61 to 41988 in 2002 [11,12] when population increased from 1.69 crores in 1961 to 3.18 crores in 2002.

Health has been a major item of spending in the budget from early years in Kerala. The annual growth rate of government healthcare expenditure during its first three decades was 13.04% surpassing the growth of state domestic product (9.81%) during the same period. Also the share of medical colleges and medical education in the health budget of Kerala has increased from 12.27 per cent in 1960 to 33.34 per cent in 1995, whereas the share of other hospitals has fallen from 82.8 to 53.72 per cent. The number of teaching doctors has increased 12.63 times in the last four decades and the subsidy for education has increased manifold. A noted feature is that 67 per cent of the government doctors and 75 per cent of the bed strength in government hospitals are in urban areas.

3.6.2 The Private Hospital Sector

The growth of the private sector is uneven across states, with states like Kerala, Andhra Pradesh, Maharashtra, Punjab, Gujarat and Tamil Nadu having a higher number of beds compared to the public sector. Between 1970 and 1990 there has been a steady accretion to total bed strength in the private sector. In 1973 private beds constituted 22.3 per cent of total bed strength which rose to 28.9 per cent during the early '80s and accounted for 37 per cent of the total in the early '90s. The under-

reporting of private institutions and bed strength is well known and hence the proportion of private beds to total bed strength may in fact be higher.[13]

During the late '80s, majority of the hospitals and nursing homes had a bed strength ranging from 5-100 beds. Located in urban areas these facilities were owned by doctors in single ownership or as partnership enterprises. In some states the smaller enterprises had spread to towns and even villages. A majority of hospitals during the late '80s had a bed capacity of less than 25 with an average of 10 beds. Only 7 per cent of such hospitals had a bed capacity of 75 or more. The hospitals and hospital beds in the private sector are skewed towards urban areas which accounted for 65 per cent, the remaining 35 per cent being in rural areas.

Managing a corporate hospital is not a viable proposition especially in view of the high cost of equipment and manpower. Hence, even corporate hospitals have sought government subsidies for financial viability. This demand appears excessive given the fact that the government already offers a number of financial concessions to corporate hospitals in the form of subsidised sale of land, reduced import duties and tax concessions for medical research.

3.6.2.1 Reasons for Slow Growth of Hospitals

New hospitals with all modern facilities are started very rarely in India. Table 3.4 shows the number of hospitals that existed in 1995 and later in 2004 in Kerala. Only 300 hospitals (all categories put together) were started during a decade.

Table 3.4

Private Medical Institutions in Kerala

Year of survey	Number of Medical Institutions
1995	12618
2004	12918

Source: Report on Private Medical Institutions in Kerala –2004, Department of Economics and Statistics, Government of Kerala.

The reasons for the slow growth of hospitals in the private sector are the following:

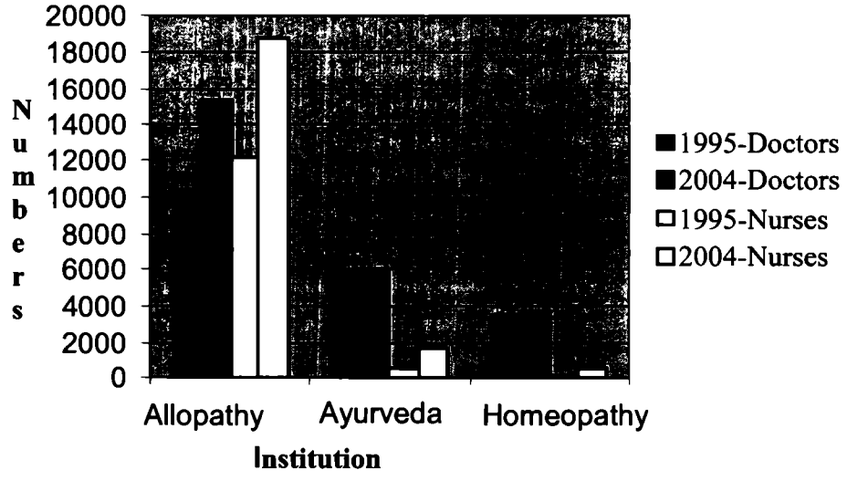
1. The return on assets is slow with a long gestation period, which discourages persons from starting new hospitals.
2. Medical technology. Ultrasound, laparoscopy, angioplasty and arthroscopy are among the technology-supported procedures that hospitals heavily pursue. These are very expensive and pay-back period exceeds many years.
3. The break-even level is very high.
4. The Profit margin of a hospital is low due to high salaries, maintenance, drugs and equipment costs. High expectations from doctors, shortage of doctors and competition between hospitals add to the huge labour cost.

The health indicators available provide evidence of a good healthy background to Keralites. Compared to other states, Kerala has the highest per capita public health expenditure. The 52nd round NSS survey reveals that the total average expenditure per hospitalisation at the National level in the private sector is Rs 4300 in rural areas and Rs 5344 in urban areas and for the public hospitals it is Rs. 2080 for rural areas

and Rs. 2195 for urban areas. The survey results show that taking together all types of hospitals (both in the private and public sectors) the average total expenditure per hospitalisation in Kerala stood at Rs. 1927 which was the lowest among the 15 major states in India. Due to the high health awareness of the Kerala people health facility utilization rate is high in the state. According to India Health Report, the number of public and private hospitalisation per 1,00,000 persons amounts to 7480 in Kerala. Here the role of private medical institutions is of great significance.

Fig 3.1

Number of Doctors & Nurses Working in the Private Hospitals



Source: Report on Private Medical Institutions in Kerala – 2004.

Department of Economics & Statistics, Thiruvananthapuram

As can be seen from Fig 3.1, there has been a phenomenal increase in the number of doctors and nurses during the survey periods 1995 and 2004. There has been almost 50 per cent increase in the number of allopathic doctors. Compared with

the other two systems of medicine, viz., ayurveda and homeopathy, the increase in the number of doctors also shows the preference of the public towards allopathy. The increase in the number of nurses also reflects a similar picture of allopathic nurses outnumbering all the other systems of medicine. Though ayurvedic system of medicine is older, public acceptance for allopathic system of medicine is far more.

The distribution of these institutions according to the systems of medicines is given in Table 3.5:

Table 3.5

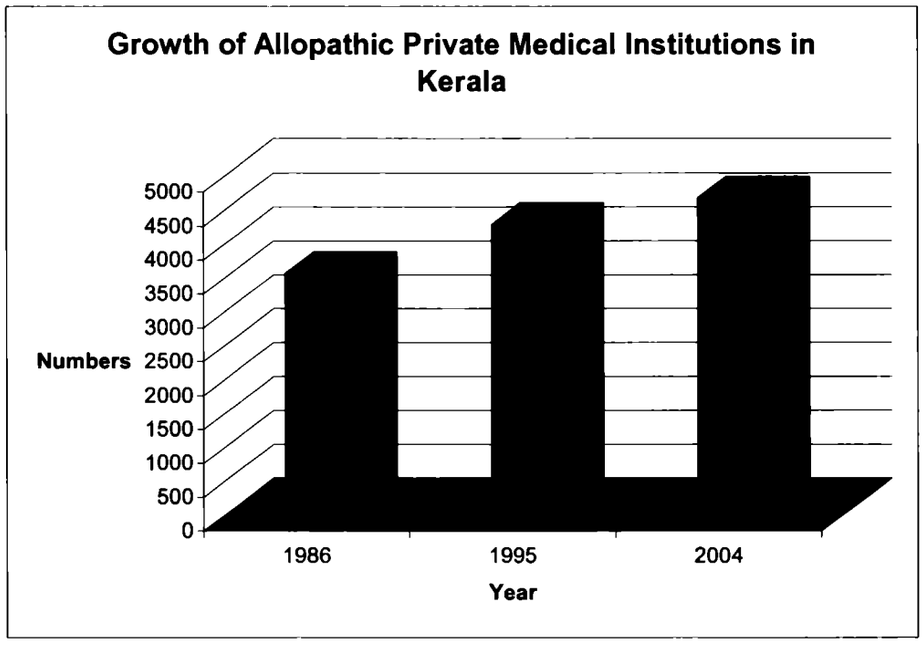
System-wise Inpatient and Outpatient Details of Private Hospitals of Kerala

System of Medicines	Facilities		
	No. of Beds	No. of inpatients	No. of out patients
Allopathy	57071	4217052	39281808
Ayurveda	5502	211620	9523224
Homoeo	813	60504	8900280
Total	63386	4489176	57705312

Source: Report on Private Medical Institutions in Kerala – 2004, Department of Economics & Statistics, Thiruvananthapuram.

Table 3.5 reveals that 4,489,176 inpatients were facilitated to utilize their services in all the three systems. In all 57,705,312 out-patients were facilitated in private medical care network. As can be seen from the Table 3.5 maximum number of beds exist in allopathy. The number of out-patients treated in allopathic hospitals is more than 50 per cent. There has been an increase in the number of hospitals from 1986 as can be seen from Fig. 3.2.

Fig 3.2



Source: Report on Private Medical Institutions in Kerala – 2004, Department of Economics & Statistics, Thiruvananthapuram

It was in 2001 that the Kerala government permitted self-financing medical colleges in the state. This led to a few new medical colleges in the private sector. These medical colleges have a bed strength of 500 or more. Rather than establishing new hospitals, many existing hospitals expanded their capacities.

3.7 PUBLIC HEALTH SPENDING BY STATE GOVERNMENTS IN INDIA

Health being a State subject the sector is financed primarily by the State Governments. Public health in the state is also financed by general tax and non-tax revenue resources and the cost recovery from the services delivered has been negligible, at less than 2 percentage. As a result, resource allocation to this sector is influenced by the general fiscal situation of the State governments. Whenever there is

a fiscal problem, social sectors such as health and education are targeted for pruning expenditures and reducing budget allocations. For example, during the period 1998, the total health expenditure as a percentage of the GDP was 5.1 per cent. Public expenditure on health was 18 per cent of the total expenditure on health. The total government health expenditure as a percentage of the total government expenditure was only 5.6 per cent.

Thus the provision of healthcare by the public sector is a responsibility shared by state, central and local governments, although it is effectively a state responsibility in terms of service delivery. State and local governments incur about three-quarters and the centre about one-quarter of public spending on health. The responsibility for health is at three levels. First, health is primarily a state responsibility. Second, the centre is responsible for health services in union territories without a legislature and is also responsible for developing and monitoring national standards and regulations, linking the states with funding agencies, and sponsoring numerous schemes for implementation by the state governments. Third, both the centre and the states have a joint responsibility for programmes listed under the concurrent list. Goals and strategies for the public sector in healthcare are established by a consultative process involving all levels of government through the Central Council for Health and Family Welfare.

The figures presented in Table 3.6 shows that budgetary allocations to the health sector during 2003-04 declined by more than 2 percentage points as compared to 1985-86 for Kerala. Despite the reduction in health budget from 7.02 per cent in 1985-86 to 4.97 per cent in 2003-04, the fiscal deficit as a percentage of the Gross

Domestic Product (GDP) recorded an increase, implying that allocation of health does not necessarily accentuate fiscal deficit.

Even more, the expenditure on health was 9.61 per cent in 1960-61. It came down to 7.53 in 90-91 and 5.67 in 2001. According to the Economic Review 2006, it is 6.3 per cent in 2005-06, whereas the World Health Organisation recommends 13 to 15 per cent as desirable. Pertinently, the population in Kerala was 2.91 crores in 1991 and it reached 3.18 crores in 2001 – an increase that demands higher health sector allocation.

Table 3.6

Share of Health Revenue Budget for Major States in India (in percentage)

States	1985-86	1991-92	1955-96	1999-00	2003-04	2004-05
Andhra Pradesh	6.41	5.77	5.7	6.09	5.21	4.8
Assam	6.75	6.61	6.08	5.25	4.39	4.36
Bihar	5.68	5.65	7.8	6.3	4.84	6.47
Gujarat	7.45	5.42	5.34	5.21	3.68	3.76
Haryana	6.24	4.19	2.99	4.08	3.63	3.35
Karnataka	6.55	5.94	5.85	5.7	4.85	4.18
Kerala	**7.69**	**6.92**	**6.81**	**5.95**	**5.42**	**5.2**
Maharashtra	6.05	5.25	5.18	4.59	4.39	3.89
Madhya Pradesh	6.63	5.66	5.07	5.18	4.89	5.08
Orissa	7.38	5.94	5.42	5.03	4.47	4.58
Punjab	7.19	4.32	4.56	5.34	4.27	4.05
Rajasthan	8.1	6.85	6.18	6.39	5.75	5.73
Tamil Nadu	7.47	4.82	6.4	5.51	5.26	4.91
Uttar Pradesh	7.67	6	5.73	4.42	5.13	5.75
West Bengal	8.9	7.31	7.16	6.3	5.23	5.04
All States	7.02	5.72	5.7	5.48	4.97	4.71

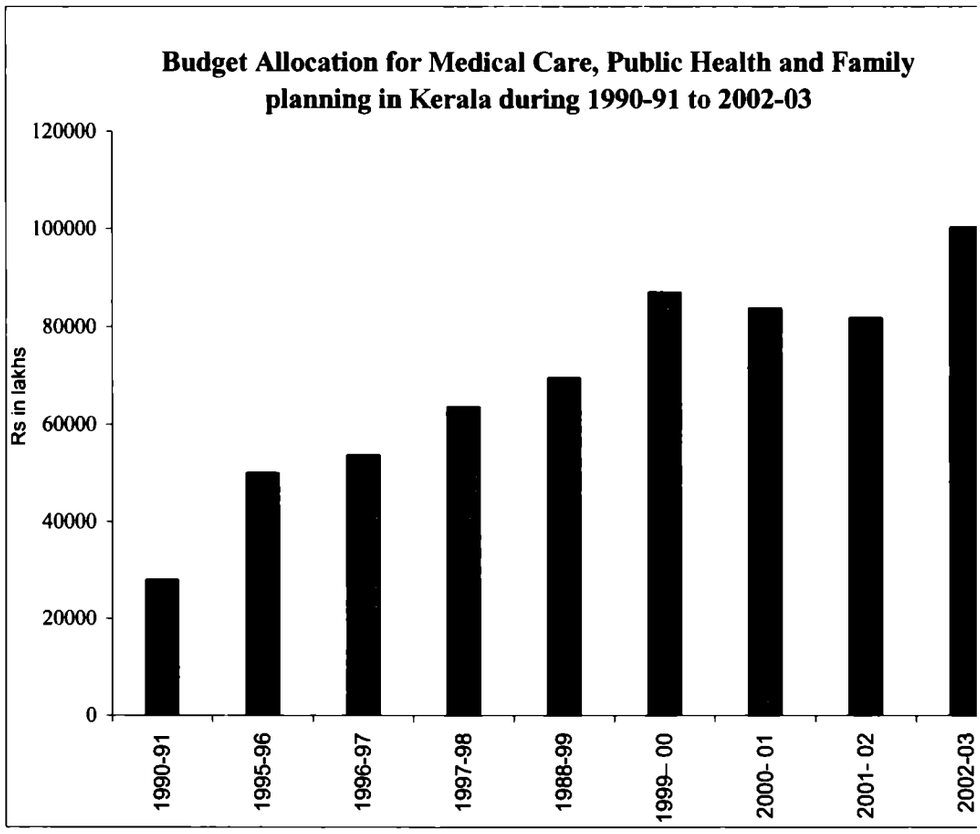
Source: Report of the National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Govt.of India, 2005.

3.8 BUDGET AND HEALTH IN KERALA

Health had been a major item of spending in the budget from early years in Kerala. The annual growth rate of government healthcare expenditure during its first three decades was 13.04%, even surpassing the growth of State Domestic Product (9.81%) during the same period.[14] But the budgetary share of health has been coming down gradually from the 1980s of 6.95% to around 5% in 2000-2001. While capital spending stagnated by mid-1980s, revenue expenditure started declining after early 1990s. Continued growth of salary component in revenue expenditure led to cutback on supplies and maintenance.

Still, the accessibility and coverage of medical care facilities has played a dominant role to shape the health status of Kerala. Medical care and public health always claimed an increasing proportion of Kerala State budget as can be seen from Fig.3.3:

Fig 3.3



Source: Budget in brief 2002-2003, Government of Kerala, Government Press Thiruvananthapuram.

An analysis of the development expenditure of Kerala which consists o medical and public health and family planning shows ups and downs in the budge allocation. When there was a steady increase from 1990-1991 onwards there has bee a dip in 2000-01 and 2001-02. The reasons attributed could be the political and socia changes in the state during that period and a shift in emphasis to family welfar schemes coupled with fiscal crisis. Fig.3.3 makes the fluctuations in allocation o funds all the more meaningful.

As can be seen from Table 3.7, Kerala's private healthcare infrastructure includes around 12,600 institutions, 70,000 beds and 20,000 doctors. In the government sector there are around 1281 medical institutions which include 105 Community Health Centers, 944 Primary Health Centers, 21 T/B clinics and 15 Leprosy Control Units. Therefore, for a population of 31,838,619 people, there exists a healthcare centre, bed, and doctor for every 2076, 259, and 587 inhabitants in the state respectively. While 48.3% of institutions, 91% of beds and 55.9% of doctors practise Allopathic System of medicine, 31.2% of institutions, 6.7% of beds and 25.9% of doctors practise Ayurvedic system. Homeopathic system constitutes 20.5% of institutions, 2.3% of beds and 15.5% of doctors, whereas the remaining 1.8% institutions, 0.3% beds and 2.7% doctors are in other systems of medicine such as Sidha and Unani.

Table 3.7

Private Medical Infrastructure in Kerala as on 2004

Item	Allopathy	Ayurveda	Homeo	Others	Total
No. of Institutions	4288	4922	3118	290	12618
No of institutions having IP facility	1958	233	45	38	2274
No. of beds	67517	2595	394	418	70924
No. of in patients	3471	79	10	6	3566
No. of out patients	35285	11823	8483	418	56009
Total patients	38756	11902	8493	424	59575
No. of Doctors	10388	5771	3476	328	19963
No. of paramedical staff	20809	2347	586	176	23918
No. of technical staff	4447	197	53	26	4723
No. of ministerial staff	6329	1961	1118	66	9474
Total Employees	41973	10276	5233	596	58078

Source: Report on private medical institutions in Kerala, Department of Economics and Statistics, Government of Kerala, 2004.

The three main systems of medical institutions treated 19.36 lakh inpatients and 809 lakh out patients during 2002-03 as against 17.64 lakh patients and 798.47 lakh outpatients during 2001-02. Total patients treated thus increased by 12.25 lakhs (1.5%) in 2002-03 over 2001-02. But the share of patients treated under each system of medicine underwent significant change in 2002-03 over 2001-02. During 2001-02 76% patients were treated in Allopathy, 5% in Ayurveda and 19% in Homeopathy.

3.9 CONCLUSION

Kerala model of economic development has been a topic of discussion among many economists world over. Our health indices are comparable with the developed nations of the world. This can only be attributed to the initiatives taken and implemented by the erstwhile king to the present government. India, in 1978, along with other WHO member-nations, became a signatory to the Alma-Alta declaration promising 'Health for All' by the year 2000 a little over two decades back. By becoming a signatory to the programme 'Health for All by 2000', India had to adopt a decentralized system of implementing healthcare. Kerala, because of the peculiar nature of the people, adopted this dictum and has reached an enviable position in health.

Today the bed-population ratio in the government sector is 1: 785 as against the private sector where it is 1:461. That is, in the government sector there is one bed for 785 people, whereas in the private sector there is one bed for 461 people. The private sector caters to the public more than the government sector.

Similarly, there is one government doctor for 5319 people, while there is one doctor in the private sector for every 2955 persons. Even when government hospitals reel under pressure due to underemployment, the private sector has almost double the number of doctors.

However, access to basic health care, especially in the rural areas, remains unavailable to a large majority. The private sector definitely has a better penetration in areas where the majority live – the urban areas. Further, because of a complete lack of regulation and control there is another large number of practitioners, estimated at

about half as many as the qualified, who practise modern medicine without proper qualifications in any system of medicine – a large majority of them are in rural and backward areas. The entire private health sector operates on a profit basis within the context of a supply-induced demand economy. Estimates based on various studies show that private health expenditure accounts for 4 to 6% of the GDP, in sharp contrast to less than 1% of the GDP which the government spends.[15]

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Chapter IV

MANAGEMENT OF PRIVATE HOSPITALS – AN OVERVIEW

CONTENTS

CHAPTER IV

MANAGEMENT OF PRIVATE HOSPITALS – AN OVERVIEW

INTRODUCTION

The private sector plays an important role in India's healthcare delivery system. Private healthcare services in the country have grown and diversified during the last two decades. This sector now consists of a range of players who provide services in both rural and urban areas. These players include individual private practitioners who provide primary level care, owners of small and medium nursing homes who mainly provide secondary care and a few large corporate hospitals that provide tertiary level care. Through a wide network of health care facilities, this sector caters to the needs of both urban and rural populations and has expanded widely to meet increasing demands. The question here is 'Who are the private providers of health in a developing country like ours?' It is conventional to define 'private' providers as those who fall outside the direct control of government (Bennett, 1992).

Private ownership generally includes both for-profit and non-profit providers. Thus private ownership would include healthcare facilities owned by individuals who seek to earn profits, clinics and hospitals owned by private employers and those operated by religious missions and other non-governmental organizations (NGOs). While private health care, in the form of small and medium enterprises like nursing

homes, has been prevalent in India for several decades, the entry of the corporate sector is relatively new.

Though the late '80s witnessed a significant growth of the corporate sector, the distribution of the private sector across the states of India remains uneven. A bulk of the private sector consists of individual practitioners, both trained and untrained, followed by nursing homes and hospitals which are owned by a single owner or in partnership. Private practitioners, in both rural and urban areas, nursing homes and hospitals are mainly located in urban areas showing a skewed distribution of hospitals.

Since the tertiary hospitals are located in urban areas and since the urban population is relatively more economically powerful than the rural population, bias has crept in that big hospitals would succeed only in urban areas. As such there is less number of tertiary hospitals in rural areas though sole practitioners and small nursing homes thrive well.[1]

Apart from the growth of private sector in providing medicare, the pharmaceutical, insurance, equipment and computer software corporations have also become important players in the health sector.

4.1 UNIQUE FEATURES OF PRIVATE HOSPITALS

Multifaceted developments in the society have made the masses more conscious of their rights. Today, we find people expecting more and more services from hospitals.

We find different types of diseases spreading due to environmental problems that increase the functional responsibilities of hospitals.

Hospitals or healthcare institutions are social organisations[2] that depend to a great extent on human resources. The ratio of people employed in these organizations are generally higher than in other type of organisations. Their quality of services is directly proportional to the quality of human resource. The recipients of the service – patients and their wellwishers – become quickly aware of the quality of the care, concern and calibre of the hospital staff at various levels.

Based on various discussions, it can be stated that private hospitals differ from other industrial organisations in the following respects[3]:

4.1.1 It is difficult to define and measure the output of a hospital. Though there are many indices like patient-bed ratio, patient-death ratio, bed occupancy ratio, etc., there is no universal standard set in India to measure the output of a hospital.

4.1.2 The nature of the work is highly variable and complex. Hospital requires the support of a multi-disciplinary team for its effective functioning. The professional bureaucratic nature gives due importance to doctors, nurses and paramedical staff. The person has the expertise and the role is different. Still they can work only in teams, which proves role clarity.

4.1.3 Much of the work is of an urgent nature and cannot be postponed. The nature of most of the jobs in a hospital is such that it cannot be postponed. In case they are not attended to, the same case may become critical or fatal. The

doctors and nurses are solely responsible for the life and future of patients they treat.

4.1.4 The activities are highly interdependent and demand close coordination among diverse professionals. Since the activities require coordination between different departments of medicine and management, unless and until there is a close coordination between them, things could go out of control.

4.1.5 The work involves a high degree of specialisation and use of sophisticated equipment, innovation and techniques. Doctors of each department is an expert in his area of work. Medical technology is advancing at a steady pace and medical professionals must update him on the changes occurring around on newer technologies and medicines.

4.1.6 Hospital personnel are highly professionalized. Their primary loyalty belongs to the profession rather than to the organisation. The oath of Hippocrates they take insist on the loyalty to their profession.

4.1.7 There exists little effective organisational or managerial control over the group most responsible (i.e., doctors) for generating work, incomes and expenditures. In a hospital, the expertise of doctors and services of nursing and auxiliary staff matter more than anybody else. Patients approach a hospital for the services they offer rather than the managerial expertise.

Many hospitals have dual lines of authority, which create problems of coordination and accountability and confusion of roles. The basic management

principle of unity of command does not apply here due to the uniqueness of the job. Junior staff, be it doctors or nurses, are expected to accept duality of command from the senior doctors/department heads and management representatives.

4.2 TYPES OF HOSPITALS

There are different types of hospitals established with the motto of offering medicare services, education and training. There is a distinction in their structure, function and performance. The classifications are made on the basis of different criteria like the objectives for which they are established, ownership pattern, system of treatment offered, and bed strength[4]. The classification of hospitals on the basis of objectives are:

4.2.1 Objectives

The first criterion for the classification is objectives. The main objective of establishing a hospital is to offer the medical services but we also find education, training and research as the secondary objectives. Thus we find classification on the basis of objectives as follows:

4.2.1.1 Speciality Hospitals

The third category under classification is meant for specific purposes. These hospitals offer specialised services in selected areas. They concentrate on a particular organ of the body or a particular disease. Maternity hospitals, Cancer centres, LV Prasad Eye Hospital, etc. are some of the examples.

4.2.1.2 Teaching-cum-Research Hospitals

These types of hospitals are established to make available to the medicos and para-medical personnel the teaching aid. These hospitals are found instrumental in

offering the educational facilities in addition to the medical services. In some situations, medical students spend one year in a teaching hospital doing clinical training, after completing the pre-clinical training in a medical college of a university.

The teaching hospitals generally have 500 beds which is a basic requirement for getting sanction under the Indian Medical Council to start a teaching hospital. As such to start a teaching hospital bed strength is a parameter. For example, Amritha Institute of Medical Sciences is established as a teaching-cum-research hospital.

4.2.2 Ownership: Classification can also be on the basis of ownership pattern of hospitals and it is broadly divided into government and private hospitals.

Hospitals in the private sector are managed by charitable trusts, companies, partnerships and sole proprietorships. Private hospitals can be registered under the Charitable Trusts Act 1920, formed under Sec. 25 of Indian Companies Act 1956, or registered under the Indian Partnership Act 1932.

4.2.3 System of Treatment: Hospitals can be divided on the basis of the system of treatment or medication offered. The various systems of medicine are **Allopathic, Ayurvedic, Homeopathic and Unani** hospitals. In these types of hospitals, we find a difference in the nature and character of treatment. Still there are some hospitals that follow a combination of treatments like Allopathy, Ayurveda, etc.

4.2.4 Size: The basis for classification of hospitals can also depend on the size of the bed strength or the population it has to cater to. In the rural areas, the primary healthcare services are delivered through three types of healthcare institutions comprising a sub-centre (SC) for a population of 3000 -5000 people, a Primary

Health Centre (PHC) for 20,000-30,000 population and a Community Health Centre (CHC) as referral centre for every four PHCs.

4.3 ORGANISATIONAL STRUCTURE

Hospital as an organisation can be described in its organisational context and organisation structure. Organisational context is defined as the social and economic setting in which an organisation chooses to operate. It also refers to all the conditions and factors external to the organisation. For a modern corporate hospital, four aspects need to be considered: external environment, organisational assessment, human resources and political processes. While external environment deals with the local community, organisational assessment deals with assessing the mission of the hospital in relation to its future environment. It must have such a structure that can anticipate problems and take quick corrective actions to remove barriers of communication and conflict. Human resource deals with the capabilities, potential, training and performance of the professional staff. The fourth factor termed as the political process involves a systematic assessment of the internal dynamics that operate in an informal manner. The only way in which the hospital can progress is through the effective use of these four aspects which can help in the planning and decision-making processes. By using this information from the four sources, the management should be able to devise an appropriate organisational structure.[5]

The organisational structure of a private hospital is totally different from that of government hospitals. Unlike the typical bureaucratic set-up of a government hospital, which is very flat and long, a private hospital has fairly thin and tall set-up.

Experts have defined organisational structure[6] differently. The most widely accepted definition is by Hudge and Anthony which is as follows:

"The hierarchical pattern of authority, responsibility and accountability relationships designed to provide coordination of the work of the organisation; the vertical arrangement of the jobs in the organisation."

Organisational structure according to Miles and Snow, is not just the organisation chart but when supplemented with the perceptions of informants on the question, 'who makes what decisions and where?' provides an overall understanding of the structure of authority in an organisation.

The conceptual exposition made by some leading authorities makes it clear that designing and maintaining the roles of different sub-systems is the basic managerial function of organising. Organising is a process, which makes it clear that those who want to cooperate would work together most effectively if they know the role they have to play in any team operation. This process also makes clear the way their roles relate to one another.

Organisational structure is important because it is concerned with the following:

(1) The division of labour in terms of departmentation

(2) Independence and optimization

(3) Structure of authority.

The purpose of an organisational structure is firstly to channelise information to the proper people. This reduces the uncertainty in taking decisions. Secondly, it

helps to distribute the authority to make decisions, so that implementation of plans is efficient and smooth. Thirdly, it is a managerial tool, which leads the organisation to achieve its goal, and fourthly the organisational structure defines and governs the relationship between units.

To evolve a good organisational structure, which has less conflicts, issues and better co-ordination, there are five constituent elements which can be varied to suit particular goals[7]. They are:

4.3.1 Formalisation

Written rules, policies, guidelines and procedures help to create a bureaucratic set up. The greater the formalisation, the lower the rate of programme change though employees get discouraged in being innovative. It was seen during the study that in some hospitals due to rigid rules and regulations, employees refused to take challenges. They seemed keen to abide by the rules more than suggesting new methods even in areas like front office.

4.3.2 Centralisation

Centralisation exists in an organisation when fewer persons take decisions. Power is in their hands alone. If the centralisation is more, the rate of programme change will be correspondingly low and there will be a greater uniformity. In a decentralised hospital organisation different points of view will emerge from the doctors, who are highly trade professionals. These differing opinions will lead to conflict.

4.3.3 Specialisation

Specialisation refers to the extent to which an organisation favours division of labour. In hospitals, specialisation of roles and functions reach high levels in intensity and extensiveness. People with different skills and abilities interact closely in a hospital where functional interdependence and close cooperation is essential. Here, medical and nursing specialisations lead to improved healthcare just as administrative professionalism leads to improved functioning.

4.3.4 Complexity

Complexity is defined as "the extent of knowledge and skill required of occupational roles and their diversity." It is also described as "the degree of sophistication and specialisation that results in the separation of work units for the purpose of establishing responsibility." Among the services, hospital is the most complex form of organisation because of its different hierarchical set-up. A person finds duality in command for junior doctors and nurses. The junior doctors and nurses are provided instructions from the department head as well as the management representative.

4.3.5 Configuration

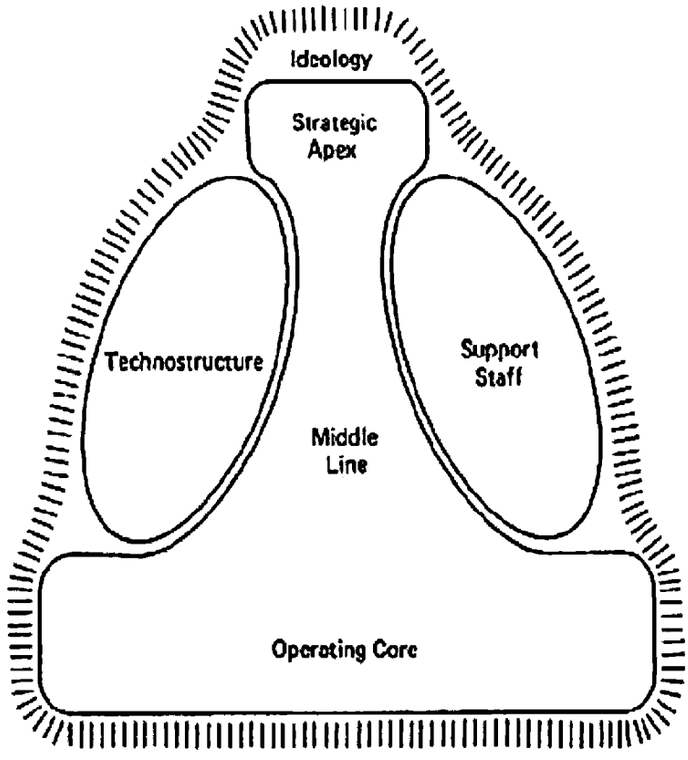
Organisational structures occur in a limited number of configurations. So the structural configuration must include criteria by which the various roles and activities can be differentiated as well as grouped together in the organisation.

The organisational configuration of Henry Mintzberg is shown in Fig 4.1.

Mintzberg[8] is of the opinion that irrespective of any type of organisation there would only be a difference in weightage / emphasis/ importance among the six basic parts of any organisation.

Fig 4.1

Six Basic Parts of an Organization



Source: Mintzberg H.: ***The structure of organizations****. Englewood Cliffs, Prentice-Hall, New Jersey 1971. p-65*

4.3.5.1. ***The Strategic Apex***. This is the top-level management having ultimate responsibility for the effective working of the organisation. It may be one

person or a small team. For hospitals usually there will be doctors as members in this zone.

4.3.5.2. ***The Operating Core***. These are employees who do the basic work of providing services. People who belong to this zone conduct the operations and operational processes. It includes doctors, nurses and nursing aids.

4.3.5.3. ***The Middle Line***. These persons connect the strategic apex with the operating core. They are intermediate managers who transmit, control and help in implementing the decisions of the Strategic Apex. In a hospital, people belonging to this level ensure that all functional supports required by the operating core are met. They ensure all the physical availabilities of departments, equipments, etc.

4.3.5.4. ***Support Staff***. They support outside the main operating workflow like canteen, pharmacy, security, etc. They do not have a direct link with the patients.

4.3.5.5. ***Techno structure*** in a hospital includes the hospital administrators, functional area managers like finance managers, marketing managers, human resource managers, public relations managers, etc.

Originally, hospital organisations had configurations similar to manufacturing organisations. Over a period of time, hospitals have evolved a unique formation. The most important feature is that the governing body, the CEO and the medical staff make up a triad. The triad permits sharing of power and authority among themselves. The Governing Body or the Board of Trustees has the ultimate responsibility of the

hospital's performance. It makes the overall policies and lays down the byelaws. The medical staff is accountable to the governing body and is responsible for the quality of medical care. It serves on the hospital committees (technical and clinical) and in this way participates in the functioning of the hospital. The CEO and the administrative staff are accountable to the governing board and have to implement the bye-laws. It is also responsible for the financial aspects, personnel and services.

There are different types of structures depending on the type of organisation, but hospitals follow the professional bureaucratic style.

Professional Bureaucracy

Organisations like universities, libraries and consulting firms and hospitals maintain power with the operating core, and are called professional bureaucracies. Such organizations can be highly effective, because they allow employees to practise those skills for which they are best suited. The only disadvantage is that sometimes specialists become so overtly narrow that they fail to see the 'big picture', leading to errors and potential conflict between employees.

A hospital must be enabled to function smoothly in teams. To accomplish the common goal among the teams in the hospital, there are specific teams formed, though they become dysfunctional after the objective is attained. The different teams are:

1. *Patient care team* (doctor, nurse, pharmacist, medico-social worker, dietician and others depending on the nature of the hospital and care provided)

2. *Investigative team* (laboratory and radiology technician, nurse, pathologist, microbiologist, biochemist and radiologist), and
3. *Supportive team* (maintenance, housekeeping, transport, aides and helpers). The coordination of work between teams and within teams is important to achieve the objectives.

4.4 DEPARTMENTALISATION IN PRIVATE HOSPITALS

Any hospital, other than the very small, is divided into departments for more effective functioning. Such divisions are for convenience. The hospital administrator should ensure that the heads of the departments cooperate and work together to achieve the objectives of the hospital.

Due to the nature of the organization, departments in a hospital is categorized into two, namely, medical departments and functional management departments. There are a number of departments in the hospitals to offer medicare services. It is the joint effort and a sense of coordination and cooperation that various departments in hospitals offer different types of services related to diagnosis and treatment of patients. Hospitals are also instrumental in promoting healthcare education. The following are the important medical departments in private hospitals:

4.4.1 Medical Departments

Departments that cater to offering different types of clinical services come under the purview of medical departments namely, department of medicine, nursing, surgery, house keeping, etc.

4.4.1.1 Department of Medicine

In the context of medical services, department of medicine plays an important role. This department is related to the diagnosis and treatment of different types of diseases. The physicians manage the department under the headship of a senior doctor. A number of junior doctors and the nursing staff help doctors in processing the medicare activities. Clinical investigations and pathological investigations help doctors in diagnosing the disease and writing a prescription. Since specialisation is not found here, general type of diseases are diagnosed and treated. A number of sub-departments exist, especially in the tertiary hospitals. Usually this department in a large hospital looks after in-patients apart from division into specialities. Each department may be divided into units. The wards are divided, more or less, on the basis of:

Speciality - each ward may offer like general wards, special wards, VIP rooms,

Acute or graded care; the acute care areas may be for intensive care of all types (cardiac, pulmonary, poisoning, etc.) or there can be specialized areas for coronary care, chest, poisoning, post-operative, etc.

Specialised wards, such as those for burns, isolation, etc. may be provided. Each ward can have facilities for treatment, investigations, diet distribution and others.

Hospitals with a department of medicine will have many special areas namely:

1. **Operation theatres:** These are often situated in different blocks. There will be pre-medication and post-operative care rooms or wards situated close-by. Continuous monitoring by the theatre team is necessary.
2. **Labour rooms,** with rooms for different stages of labour and delivery.

3. **Premature units** and nurseries, which include neo-natal, and post-natal care.
4. **Common investigative and ancillary facilities:** These are often located strategically between the outpatients and inpatients, so that they can serve both the areas; so also pharmacy and medical records department.
5. Central sterile supply, dietary, stores, maintenance, house keeping, laundry and other services are also located strategically such that the approach is easy.

4.4.1.2 Department of Surgery

Like the medicine department, a senior surgeon heads the department of surgery. A number of junior surgeons are to assist him while performing surgeries. Though the surgeons bear the responsibility of heading the department they need a number of infrastructural facilities to conduct operation. In addition to the investigation report, the surgeons also need well-sterilised instruments and infection-free operation theatre. Besides, a number of nursing staff is also needed to assist the doctors and help the patients. Some of the important sub-departments related to surgery are Orthopaedics, Ophthalmology, Gynaecology, General Surgery and ENT.

4.4.1.3 Department of Nursing

The primary purpose of the nursing department is to give comprehensive, safe, effective and well-organized nursing care to patients[9]. Nursing department constitutes the largest single group of hospital employees averaging almost 50 per cent of the total staff. They are the mainstay of the hospital from the standpoint of supporting administrative requirements, giving effective patient care and promoting good public relations. This department serves as a focal point for much of the administrative

coordination. There are two major types of functional responsibilities discharged by them:

Bedside nursing: This includes receiving patients, investigating patients, sending them to the respective clinics, rounds with the Medical Officer and assisting the doctors.

Other than bed-side nursing: This includes IP registration, instructions to servants and other personnel related to proper sterilisation, routine drug, supervision and so on.

4.4.1.4 Department of Hospitality and Housekeeping

Good housekeepers need technical knowledge of housekeeping. It is essential that the housekeepers be taught the fundamentals of home economics and the physical sciences considered essential to their defined duties. The important functions of the housekeepers are routine cleaning, dusting, mopping, window and wall-washing and thus helping in keeping the place health-friendly and clean. They are also supposed to perform the task of bed-making.

4.4.1.5 Department of Pharmacy

Generally, the pharmacy department of a hospital is found clubbed with the central sterilisation and stores. Hospital pharmacy is an important dimension of hospital management, especially on the medical side. The staff is required to be well trained so that they perform efficiently the responsibility of labelling, storage and distribution of drugs and sterilised material. Pharmacy plays an incremental role in improving the quality of medicare services. It is essential that a separate department under the direction and control of professionally competent and legally qualified

pharmacist is created. The pharmacists bear the responsibility of making it sure that quality and right medicines are supplied to the patients. They are found responsible to regulate the supply of spurious drugs. This makes it essential that personnel with suitable qualifications and experience are recruited, so that the image of hospitals and doctors is not tarnished.

4.4.1.6 Department of Pathology and Clinical Laboratory Services

Laboratory services help in right diagnosis. The laboratory services include providing information to assist the physicians in diagnosing, treating and preventing the multi-dimensional disease. The services also include enriching of the training programme and help the researchers to invent something new. To be more specific, in the surgical services the laboratory services help surgeons in coming to the right conclusion. And so far as the services related to the department of medicine are concerned, the laboratory services help the physicians in different ways. It is quite natural that the department of Pathology and Laboratory Services are under the direct control of experienced physicians.

4.4.1.7 Department of Radiology

The radiology department of a hospital bears the responsibility of making the diagnosis more authentic by using radiography, fluoroscopy, radioisotopes and high voltage acceleration. A competent radiologist is to head the department who should have specific training and experience in the area of expertise. By developing a reliable diagnostic and therapeutic department in hospitals, the radiology department contributes substantially to the process of using the potentials of doctors.

4.4.1.8 Out-Patient Department

Increasing pressure on hospitals has made the task of admission/registration very difficult. In many cases patients are not admitted; because a large number of patients can be treated even without considering them as in-patients. Emergency clinic is a major unit of the out-patient department. Since the in-patient services are based on the observations of out-patient services, the hospital managers need to concentrate their attention even on the out-patient services. This department provides ambulant care also. The out-patient department, in addition to routine care, may organise special clinics for ante-natal, post-natal, hypertension, cardiac, diabetic, pulmonary, physiotherapy and rehabilitation, occupational therapy, vocational therapy and counselling.

4.4.1.9 Department of Causality/Emergency Services

For serious type of patients it is pertinent that the medical aid are made available on time. This explains how the emergency services of the hospitals play a special role in projecting the positive image or even tarnishing the positively projected image. The doctors, while managing the department, need to deploy those staff found personally committed and professionally dedicated, so that the treatment process start immediately. Just as the other staff the medical and para-medical personnel also should have an in-depth knowledge of behavioural management and empathy. Time management plays a contributory role in managing the department; because even a delay of few seconds may result in irreparable losses. For improving the quality of

emergency services, a team should be provided along with emergency infrastructure facilities like power, oxygen, life saving drugs, etc. round-the-clock.

4.4.2 Functional Areas of Management in Private Hospitals

Just like the medical departments, hospitals require a good integration of management departments. Some of the common functional departments of a hospital are:

4.4.2.1 Department of Finance

"Hospitals are both labour and capital intensive. Latest machines both for diagnosis and treatment have to be purchased. A modern hospital has to start new specialities and buy advanced equipments and appoint consultants in the respective areas. This will result in keeping an inventory of pharmacy and other supplies. By starting a new speciality department will not immediately increase hospital revenue, but at the same time outgoings on salaries, interest on loan to acquire equipment, etc. commence from day one. In many of the hospitals, more than 60 per cent of the allocated finance is required to be spent on salaries and wages or as establishment expenses, another 25 per cent to 30 per cent on stores and consumables. These expenses arc continually rising."[10]

While managing finance, the hospital managers bear the responsibility of identifying the changing requirements of inputs, formulating a pragmatic budget, paving avenues for the generation of finance preferably from the internal sources and more so regulating the unproductive expenses. He/she is also supposed to act as a financial manager of non-profit making organisations and therefore maximum

precaution is required at different stages of making the financial decisions. During the study, it was understood that all hospitals had a finance officer or manager who was professionally qualified in finance.

On an average, India has one bed for 1300 persons, whereas in the USA there is one bed for 170 persons. The paying capacity of the people in India is very low and so they expect the government, municipality or local bodies to provide healthcare at minimal charge. Similarly, when the USA has a per capita income of $ 15,390, India has only $260. To come to the level of the USA, India must have 50 lakh beds as against the present 6.65 lakhs[11]. So during the last decade the private sector has stepped up participation by starting many corporate hospitals and other private hospitals under various managements like trusts, societies, etc. However, not all persons can afford the charges levied by these private hospitals.

4.4.2.2 Department of Human Resource Management

On the one side are the patients of all ages and backgrounds, some appreciative and some disgruntled and on the other are the highly qualified medical staff, nursing staff, paramedics, technicians, therapists, ward boys, clerks, maintenance staff and the administrators - all interacting with one another[12]. The managements of every hospital must take due attention to establish an appropriate relationship between different categories of personnel. Since a team of different categories of personnel offers medicare service, the hospital administrator should estimate the requirements and process the recruitments with the support of concerned specialists. While recruiting, it is imperative that quality people especially in terms of

professional commitment must be appointed. A proper appraisal system would help in assessing the good from weak employees and based upon that rewarding, training or even dismissal could be decided upon.

Thus HRM function is very critical in a hospital and cardinal for its effective and efficient operation. Hospital managers should make possible a fair synchronization of performance orientation and employee orientation. A fair blend of these two would make available value-based, personally committed and efficient personnel.

Objectives of Human Resource Management in Hospitals

In a hospital with effective HRM policies and practices, the decisions on HRM are also strategic decisions influenced by strategy and structure. As such objectives must be framed as

a) to achieve and maintain good human relationships.

Building strong cultures is a way of promoting each hospital's goal, in that "a 'strong culture' is aimed at uniting employees through a shared set of managerially sanctioned values ('quality', 'service', 'innovation', etc.) that assumes an identification of employee and employer interests."[13]

b) to enable the employees to make maximum contribution to its effective working.

Hospitals that provide a desirable and conducive working environment attract the best people. The Human Resource Department in hospitals must continuously get involved in effectively implementing its philosophy of employee centric policies, a

great learning place, freedom to think, evolve and implement and an informal work culture that is most suited to them. Thus by creating a conducive work environment it facilitates the employees to develop and contribute in keeping with the stated vision and mission of hospitals.

c) to ensure respect and well-being of the employee.

Every job must be accepted and given due recognition. Due to the nature of the type of work in the hospital, there have always been issues of ego clash. There have been clashes between doctors and doctors, doctors and nurses, etc. A good human resource department should be able to tackle them with ease through properly well laid down policies.

d) to assure employees' development, so that he contributes his best.

With effective human resource management policies, employees should be made to feel as a resource and that they can contribute to competitive advantage. It is an accepted fact that competitive advantage is gained through well-educated and trained, motivated and committed employees at all levels.

e) to ensure employees' satisfaction to get their maximum contribution and co-operation for the hospital.

Employee turnover is highest among employees who are not satisfied with their jobs. Because qualified employees are becoming more scarce and difficult to retain, organizations need to focus on increasing employee satisfaction.[14] Employee satisfaction is supremely important in any hospital because efficiency of clinical and non-clinical staff depends on this. If your employees were satisfied they would

produce superior quality performance in optimal time and lead to saving of lives and time. Satisfied employees are also more likely to be creative and innovative and come up with breakthroughs that allow hospitals to grow and change positively with time.

4.4.2.3 Marketing Management of Hospitals

Another important dimension of functional management is marketing of services generated by the hospitals. This constituent of management occupies a place of outstanding significance because offering quality medical aid is now becoming more expensive. The hospitals of today need world-class technology and the supporting infrastructural facilities. It is also true that all the patients are not in a position to afford the expensive services offered by the private hospitals. Besides, a large number of patients are not even in a position to bear the cost-based services. So the managers have to adopt a fee structure that on the one hand removes the problem of financial crunch, and, on the other hand, also ensures cost-effective quality services to the masses. The managers are required to adopt a discriminating pricing strategy in which the users are supposed to pay on the basis of income or make an advocacy in favour of a pocket-friendly or user-friendly fee structure. The product uniqueness generates attractions, which require an optimal blending of core and peripheral service: but, to be more specific, it is seen that in hospitals core services establish an edge over the peripheral services.

The most important thing in the marketing management of hospitals is the outstanding quality of core services since the problem is of sensitive nature. Unlike other organisations, the users availing the services of hospitals would hardly insist on

the peripheral services if they feel that the core services made available to them are of world class.

Unlike other services, a marketing department is very rarely seen in hospitals. For hospitals that are catering to the local population, the activity of this department is confined to more of public relations work. Giving advertisements when an expert or a famous doctor joins, or when a new equipment is erected or imported, when unique medical cases are attended to and it becomes successful, etc comes under the preview of the marketing function of a hospital.

For hospitals that have an international presence, the marketing department does more of strategic market development of the main service-medicare. It is this department that looks into possibilities of international collaboration and work related to the same to have a global presence.

4.4.2.4 Material and Stores Department

A number of materials are used in the process of diagnosis and treatment. The important functional responsibilities are planning for material requirement, estimating the demand, procurement, stocking and use. In majority of the hospitals, almost 40 per cent of the budget is found for materials. It is essential that the medical and para-medical staff is made available the required materials in tune with the standards and specifications fixed in consultation with the experts. This focuses our attention on quality, time and demand. By and large, almost all the hospitals fail in managing the materials in a proper manner. Keeping in view the importance of materials in improving the quality of medicare services, it becomes pertinent that a separate

department manages materials. Purchasing process should be separated from the hospitals because in majority of cases irregularities are found in the process of purchase. This makes it essential that the concerned experts make available the requirements in terms of quality and quantity to the hospital managers at the right time. It is important that a hospital manager follows systematic and organised efforts for purchasing materials which would not only improve the quality of materials used in the process, but would also make the process cost-effective.

In different types of hospitals, different types of materials are used. For example, medical items such as perfusion materials, surgical disposables, instruments, electrical, mechanical and civil engineering items for maintenance, house-keeping materials, linen, bio-medical equipments, spares medicines and drugs, stationary items, food and beverage materials. The Advisory Committee for the Development of Surgical Instruments, Equipment and Appliances (1963) identified 3200 items of instruments and equipment being used in a hospital. This makes it clear that a hospital manager needs to minimise the number of materials to be used, so that the function of planning and control does not become difficult.

4.4.2.5 Department of Records

To promote research and to benefit patients it is pertinent that due weightage is given to the management of records. For this a separate department for records is recommended, so that, the management information system gets the required information, especially from the internal sources. The management of records simplifies the task of making an appraisal of the functions or workings of the hospitals

and their personnel. It is significant that records present a comprehensive picture of patients' illness with the physical findings and special reports such as X-ray and laboratory reports. All the records are required to be properly filed and today we can use information technology even for putting in memory the records. It is obvious according to the size of the hospital the departments would change.

Figure 4.2 shows an organisational structure of a 700-bed super speciality hospital in which each department is regarded as a unit by itself. These are corporate hospitals, which perform, in a functional bureaucratic style and where each department is a function by itself.[15]

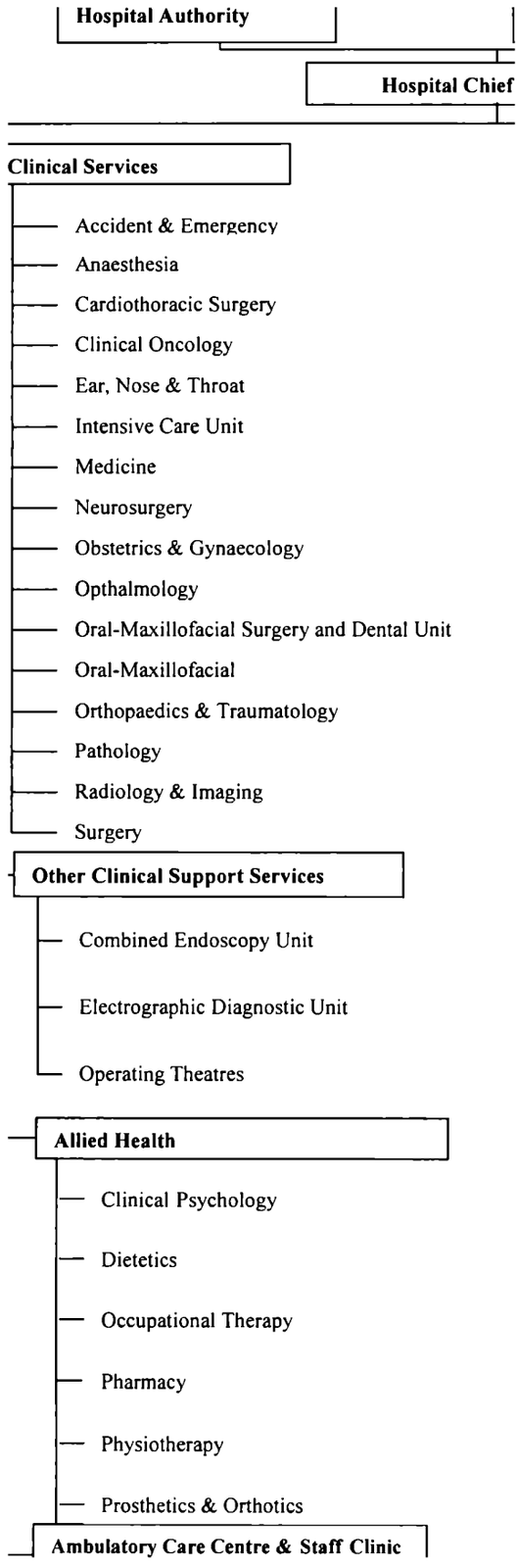
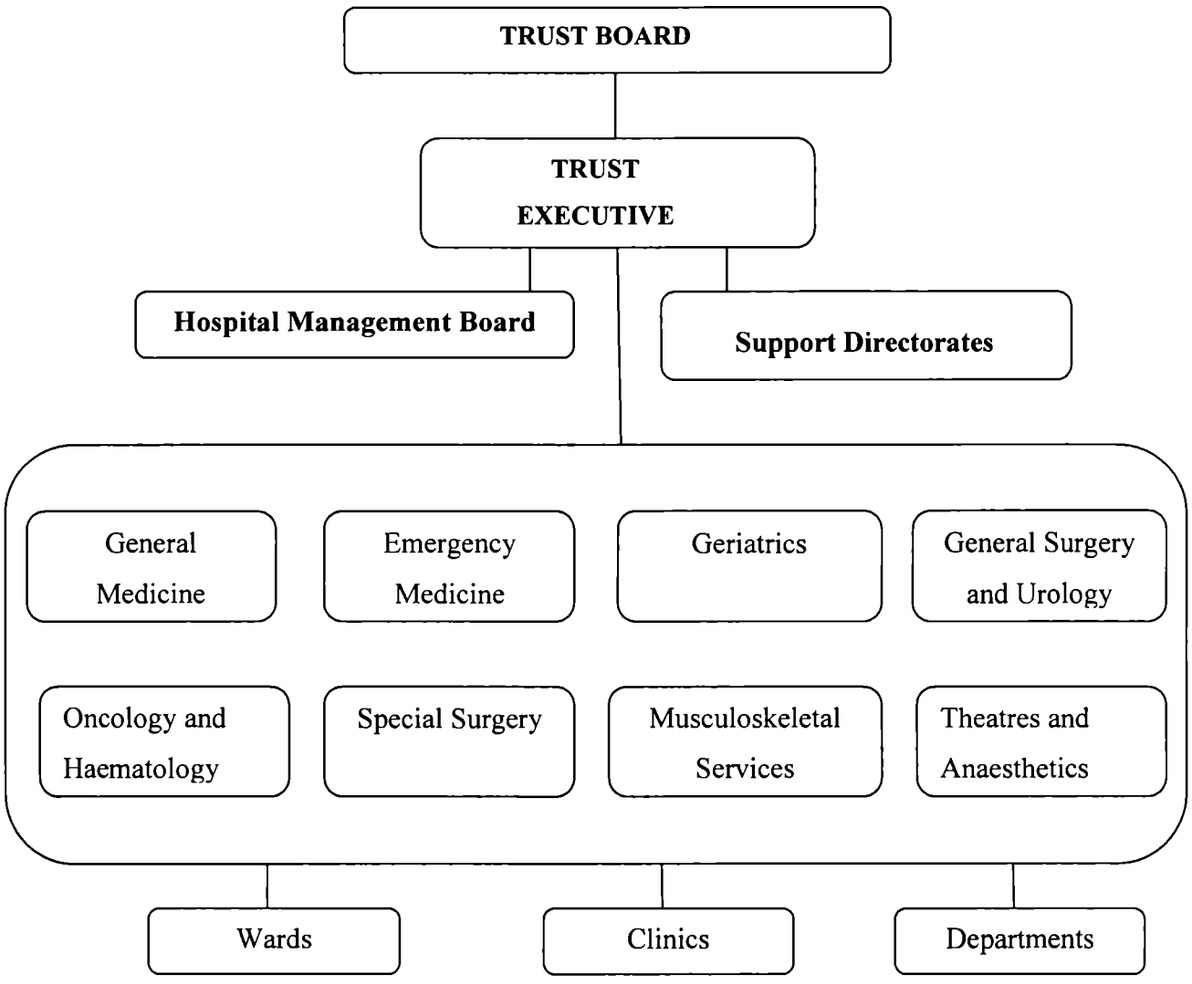

Hospital Authority
Hospital Chief
Clinical Services
Accident & Emergency
Anaesthesia
Cardiothoracic Surgery
Clinical Oncology
Ear, Nose & Throat
Intensive Care Unit
Medicine
Neurosurgery
Obstetrics & Gynaecology
Opthalmology
Oral-Maxillofacial Surgery and Dental Unit
Oral-Maxillofacial
Orthopaedics & Traumatology
Pathology
Radiology & Imaging
Surgery
Other Clinical Support Services
Combined Endoscopy Unit
Electrographic Diagnostic Unit
Operating Theatres
Allied Health
Clinical Psychology
Dietetics
Occupational Therapy
Pharmacy
Physiotherapy
Prosthetics & Orthotics
Ambulatory Care Centre & Staff Clinic

Figure 4.3 shows the organization chart of a hospital registered as a trust. These hospitals are registered under the Charitable Trusts Act, 1920. They work in professional bureaucratic style.

Fig.4.3

Organisation Chart of a Hospital registered as a Trust



The hospitals can be successful in offering to the ailing patients the required medical aid only if the functional areas are also managed properly. The general

management functions[16] of planning, organising, directing and controlling are ubiquitous functions that are carried out by all the clinical experts and managers of a hospital, whereas the operative functions of Human Resource Management are functions-specific as shown in Fig.4.4. The functional and operative functions should be blended and managed professionally. Leading private hospitals have started becoming more productive with the support of a technology-driven information system. Hospital Information Systems (HIS) helps management to manage the information related to the developments and workings of hospitals either manually or with support of sophisticated information technology.

Management of hospitals include planning, organizing, staffing, directing, communicating and controlling a social institution professionally thus making all the facilities available to the patients in a hassle-free manner.

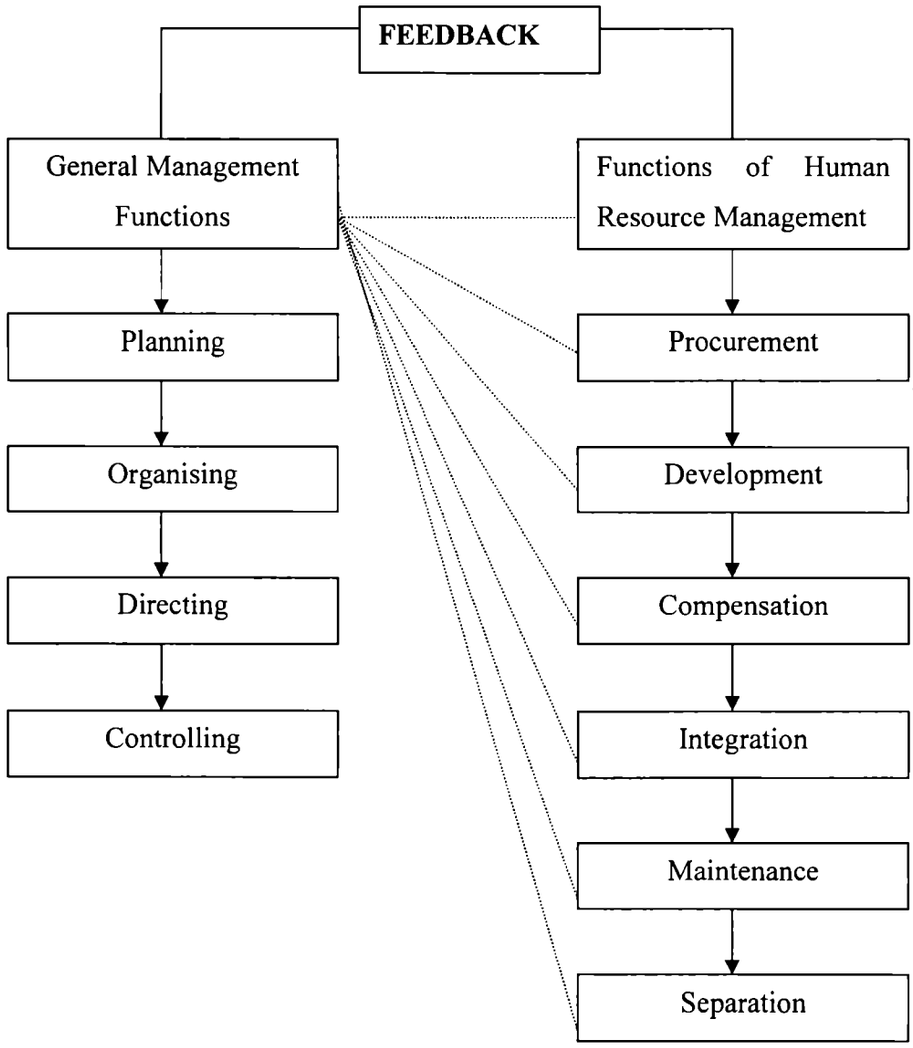
Planning the activities in a hospital could be short-range plans, medium-range plans and long-range plans. Short-range plans could be for deciding about the sequences of operations keeping in mind the availability of doctors, facilities and staff. Medium-range plans could be arranging and scheduling training programmes, and long range plans could be about hospital expansion activities, recruitment, etc.

The professionals managing the hospitals are expected to be aware of all the principles of management. The key functional management areas in a hospital are management of human resources, management of finance and management of marketing of hospital services.

Managing the human resources in a hospital is very vital due to the nature of work. Senior doctors who need not necessarily from part of management have a bigger role in the success of the hospital. They have to be supported well by a good team of nurses and auxiliary staff and an excellent and supportive management. The liaisoning between the doctors and the management can be done only with the help of a good hospital administrator or manager as can be seen from Fig 4.4.

Fig 4.4

Parallel model of Management function and HRM function



4.5 HOSPITAL MANAGER OR ADMINISTRATOR

The fact that management of hospitals by professionally sound administrators or managers provide a large number of benefits. Quality medi-care services to the patients and proper development of hospitals are the key objectives, which cannot be fulfilled satisfactorily unless the hospitals are managed professionally.

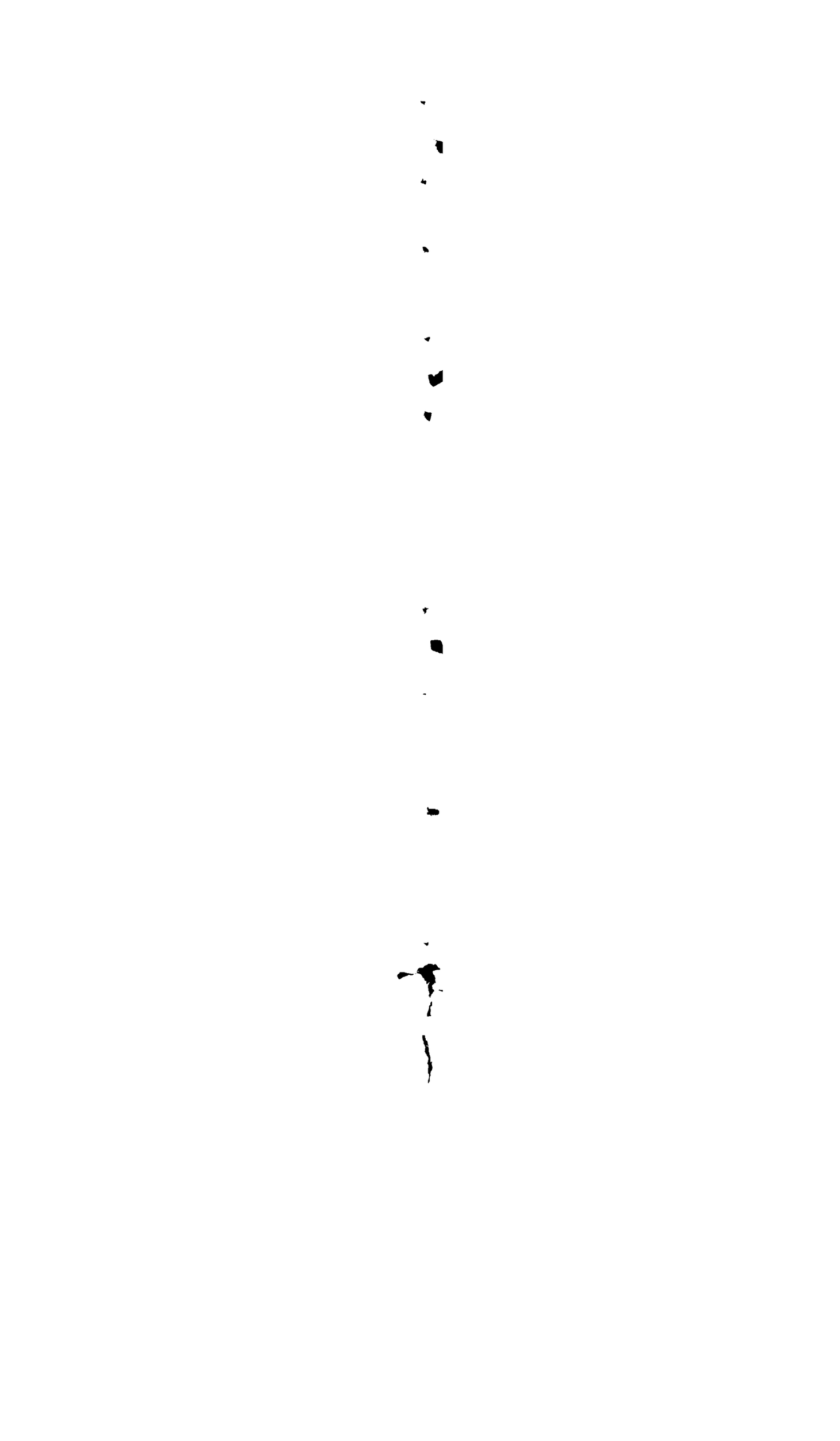
The policy panels like Mudaliar Committee (1961) and Siddhu Committee (1978) have made it clear that hospitals need to be managed by personnel having managerial experience. The private hospitals have been found evincing their interests in managing hospitals professionally. All healthcare institutions, while selecting and developing managers, need to assign due weightage to the following attributes of candidates:

4.5.1 A hospital manager needs to be professionally qualified.

A hospital manager needs to be professionally sound and qualified. Managing hospitals is a multi-disciplinary task. It is necessary that the hospital manager must acquire professional skill and knowledge to handle matters of diverse issues between doctors, nurses and the relatives of patients. He should be qualified in hospital administration, so that he is competent enough to handle various management issues of hospital like general management, administration, human resource, etc.

4.5.2 Manager needs to be candid.

The managers are required to ensure their credibility by defining specific, operating standards and developing ways of self-policing, showing hospitality to



critics, recognizing the legitimacy of different opinions and avoiding litigations as a way to work out or resolve conflicts.

4.5.3 He should be emotionally strong.

Efficient managers should not only be emotionally strong, but also know to emotionally urge employees to battle the challenges on account of innovative efforts. Since he needs to tackle patients and their relatives the hospital manager must have the ability to control emotions and look confident.

4.5.4 A hospital manager should have human values.

The managers may be professionally sound, but if they lack humanity the real constraints and handicaps obstructing the process of quality medicare would not be taken due care of. He must be ethical and value driven.

4.5.5 A manager should be personally committed.

It is personal commitment that motivates one to work even if the working conditions are not conducive. In many small hospitals there will not be a conducive working environment. Even in such situations if there is a mind for commitment things would be better.

4.5.6 A manager must be professionally committed.

A professionally committed manager would keep himself or herself all the time engaged in enriching their professional excellence. He/she should have patience, an in-depth knowledge of behavioural management, capacity to understand problems, possess ethical and moral values, high communication skill, influencing personality, etc.

These qualities of a hospital manager makes it clear that developing a sound hospital manager is a difficult task and requires proper education and training. Thus an ideal hospital manager should have futuristic vision, dynamism, respect for others, spirit of sacrifice, high behavioural profile, ethical and human values, carefulness, candour, empathy and an optimal mix of different traits.

4.6 SCOPE OF HOSPITAL MANAGEMENT

Smooth working relationships between doctors and nurses are a prerequisite for efficient delivery of health care. This has often been overlooked and managements expect committed and loyal employees who in turn expect a conducive work environment. The following facts testify the importance of hospital management:

4.6.1 Formulation of pragmatic plan

The most important thing for the proper functioning and an optimal development of an organisation is the formulation of a rational plan. Such a plan should be pragmatic and implementable within the stipulated time and budget. The hospital planners formulate short and long term plans keeping in view the expected number of the potential users.

4.6.2 Formulation of an efficient and personally-committed team

A personally committed team has to be constituted in consultation with the specialists of the respective areas. The quality and number of assisting personnel, the supporting equipment and the infrastructural facilities required by a particular team can only be finalised by experts.

4.6.3 Availability of supporting infrastructural facilities

For performing effectively, efficiently and timely it is pertinent that the hospital administrators know about the supporting infrastructural facilities such as light, water, oxygen, emergency drugs, dresses and instruments in the right order and equipments in the proper condition, so as to make them available for working even in emergencies.

4.6.4 Optimising the cost

The hospital administrators are supposed to be well aware of how and in what way the administrative and other unproductive expenses are to be made optimal to the changing requirements. The wastages of water, light, poor maintenance and operation of machines and equipments, mismanagement and unfair practices in the purchase of materials, stores, etc. increase the operational costs. A close monitoring of these and similar other expenses will help in optimizing the cost.

4.6.5 Acceleration of overall productivity

Hospitals need to increase productivity through efficiency. This requires proper use of technology and human resources. If machines and equipments are used in tune with their potentials the medical and para-medical personnel can work efficiently. The efficient management of hospitals not only makes the process cost-effective, but also increases the overall productivity, which in turn increases the strength or potential of hospitals.

With a simple three step method, hospitals can manage their labour costs through increased labour productivity.[17]

Step 1. Determine the current manpower ratio (salaries, contract labour, and fringe benefits divided by total revenue). Include any non-employee labour costs, such as agency fees and outsourced services.

Step 2. Set positive overall labour ratio goals – that is, a ratio less than the median (for example, 52.2 per cent). If currently the hospital ratio is unfavourable to the median, set initial goals to get to the median. If the hospital is at the median, set goals at 1 or 2 per cent less in the upcoming goal-setting period (6 to 12 months from now).

Step 3. Develop a labour productivity system that will help the hospital determine the level of hours needed per unit of service. Each department should have its own productivity standard. Then, on a daily, biweekly, and monthly basis, labour productivity information should be collected, reported, and distributed to the department heads so that any necessary action can be taken to ensure meeting the goals.

4.6.6 Creativity in the promotional efforts

By creative promotional measures, the authorities will have to focus on advertising and publicity since these are the measures to influence the public. These promotional efforts could be through advertising when a new specialist joins or new equipments arrive at the hospital. Any novel procedure in treatments could also be publicized to create awareness among the public about the hospital and facilities available.

4.6.7 Management of human relations

The doctors and para-medical personnel serving hospitals need an in-depth study of behavioural management so that the possibilities of indecent behaviour and confrontation with the patients and attendants are reduced.

4.7 HUMAN RESOURCE CLIMATE

Organizational climate is often defined as a simple aggregation of psychological climate in an organization [18,19]. Organizational climate connotes an organizational unit of theory; it does not refer to the climate of an individual, workgroup, occupation, department or job. Other labels and units of theory and analysis should be used for the climate of an individual and the climate of a workgroup[20]. Climate was viewed as a summary of perceptions workers share about their work settings. Climate perceptions summarize an individual's description of his or her organizational experiences rather than his or her affective evaluative reaction to what has been experienced.[21].

The word 'Organisational climate' is not of recent origin. Several studies have tried to identify the specific factors in the work environment that seem to influence organizational climate. Campbell, Dunnette, Lawler and Weick[22], after a review of four studies, identified four dimensions that seemed to be common: individual autonomy, structure, reward and consideration and warmth and support. Another study of Litwin and Stringer[23] identified nine dimensions of organizational climate like structure, responsibility, reward, risk, warmth, support, standard, conflict and identity. Muchinsky (1976)[24] analysed the Litwin and Stringer climate

questionnaire and found six derived dimensions, which he referred to as interpersonal milieu, standards, general affective tone toward management, organisation structure and procedures, responsibility and organizational identification. Lawrance, James and Allan Jones (1974), [25] who tried to identify the factors influencing climate, grouped them under five heads: Organisational Context, Organisational Structure, Process, Physical Environment and Systems and Values and Norms.

On the basis of the earlier stated and several other studies, we can come to a conclusion that Structure, Reward, Personal and Interpersonal factors basically influence the organizational climate. Though much cannot be done with structure of any organization other than superior-subordinate relationships and issues related thereon, all other factors have direct bearing on the human resource department of any organization, be it hospital or not. If issues related to these factors are given due importance there will be a smooth environment to work that enhances performance. Thus human resource climate assumes great importance in today's organizations.

In this context a good human resource department has to look deep into all aspects of the three factors namely:

- Personal
- Interpersonal and
- Reward systems of organizations.

To enhance the HR climate, the human resource manager must necessarily look into finer aspects of job allotted and the policies and procedures related to all employees. A broad area to be looked into includes the work itself, cooperation

between employees, career opportunities, working conditions, performance feedback, confidence in management, freedom of work, fairness of pay, approach of top management towards employees and retirement policies. All the above-mentioned factors constitute the human resource climate of an organization.

4.7.1 Characteristics of Human Resource Climate

a) A tendency at all levels starting from top management to the lowest level to treat the people as the most important resource. Showing that the hospital is employee-centric is the first and best method to assure a good human resource climate. It is the fact that human resource is one of the most valuable assets in a hospital. It should be conveyed to the employees through well laid down policies that managements care for them.

b) A perception that developing the competencies in the employees is the job of every manager/supervisor. This responsibility should be shouldered by department heads of management and medicine.

c) Faith in the capability of employees to change and acquire new competencies at any stage of life. The fact that change is constant and that learning is un-ending should instil interest among employees to learn more.

d) A tendency to be open in communications and discussions rather than being secretive (fairly free expression of feelings). Suppressed feelings of anger explode in various forms when not warranted for. Such instances lead to formation of unions in hospitals. To avoid such instances, employees must be given the freedom to express their opinions.

e) Encouraging risk taking and experimentation. If the employees have confidence and support from management, they will try to experiment newly acquired skills.

f) Making efforts to help employees recognize their strengths and weaknesses through feedback. Performance appraisal is used widely in all types of hospitals. By using a transparent performance appraisal form, each employee must be given feed back on their strengths and weaknesses. This system helps the employees themselves and the hospital.

g) A general climate of trust. Trust is a foundation for relationships. Every organization expects a long-standing relationship with performing employees and vice- versa. In order that such relationship exists, the management should be able to instil confidence in their employees.

h) A tendency on the part of employees to be generally helpful to each other and collaborate with each other. If there is a conducive work environment there will be co-operation among employees.

i) Team spirit is a watchword in today's work environment. More so in hospitals since every activity can be conducted only in teams. Teams fail only when there is lack of clarity between people. In order that failures do not happen in hospitals, all team members must cooperate and understand each other and the situation.

j) Tendency to discourage stereotypes and favouritism. A good HR climate should never reflect any sort of favouritism to any person or to level of people.

k) Supportive personnel policies are the crux of a good HR climate. The human resource department must take due care while drafting policies for employees.

l) Supportive HRD practices including performance appraisal, training, reward management, potential development, job-rotation, career planning, etc., adds up to a conducive human resource climate in hospitals.

4.7.2 Promoting an Appropriate Organisational Climate and Culture in Hospitals

Almost all the management experts believe that effectiveness of an organisation is considerably influenced by the organisational culture[26]. The quality of environment at the workplace plays an incremental role in governing the organisational culture. The organisational culture would play an incremental role in improving the level of efficiency of everyone working in hospitals. The government hospitals need a culture in which the policy makers need to think about the quality of environment at the workplace. Organisational culture is the general pattern of behaviour, shared beliefs and values that members have in common.

Culture can be inferred from what people say, do and think within an organisational setting. It involves the learning and transmission of knowledge, beliefs and patterns of behaviour over a period of time, which means that an organisational culture is fairly stable and does not change fast.[27] It often sets the tone for an organisation and establishes implied rules for the way people should behave.

Generally, hospitals working in the Indian environment face a number of problems. The relationships among the different categories of employees, if not sound, will influence the culture of an organisation. This, in a very natural way, makes the quality of environment at the workplace very unfriendly in which all the

personnel having values and a sense of respect will find it difficult to work. The process that results into a domination of inefficient people at the workplace and the process of degeneration of efficiency start gaining the momentum.

These facts make it clear that organisational culture is the off-shoot of organisational efforts. The most important thing influencing the process is quality of environment at the work place. If the medical and para-medical staff do not get the supporting infrastructural facilities, and if they are constrained by the negative attitudes of the boardrooms or the policy makers or the top-level management, the task of the middle-level management will become much more complicated. It is against this background that we find doctors not successful in establishing a work culture and necessitating the presence of an efficient, value-based, professionally- and personally-committed hospital manager.

The quality of environment at the hospitals needs an intensive care if the work culture has to be improved. Organisation and departmentation play an effective role in making possible an appropriate organisational culture. If the hospitals make possible departmentation in which cooperation and coordination are possible, goals are set with a great deal of participation. Authority is widely defined and decentralised, people are evaluated on the basis of performance criteria, training is imparted in many functional areas, concerted efforts are made to develop people, participative leadership is practised, communication flow is top-down - bottom-up and horizontal and diagonal and individual employees exercise a great deal of self-control. The employees working at different levels and in different capacities take pleasure and the operational efficiency is accelerated. They face a number of constraints and

difficulties, but are not in a position to remove the same. They do not like to work and the policy decision makers promote them in the very context by degenerating the quality of environment at the workplace to a point from where no return appears feasible.

The private hospitals on the other hand creates an appropriate work culture because they assign due weightage to the organisational culture. The doctors, managers and even the para-medical staff participate in the policy-decision making processes. They define and set the goals knowing well their potentials and are successful in facilitating the same. If the senior doctors and managers create a favourable climate and if they are found value-driven, there will be less scope for degeneration. The quality of healthcare services is found superior because all the employees irrespective of the rank and position hold interest in accomplishing the departmental and organisational objectives. The value-driven managers and doctors are found interested in motivating the employees by taking care of their expectations at the work and living places. This makes the way for personal commitment. It is against this background that they have been found establishing an edge over the government hospitals. There is no doubt that we find a few of the government hospitals working in the same direction and they were successful in creating a special position. Thus managers, top-level management and other employees create the climate for the hospital.

4.8 TOTAL QUALITY MANAGEMENT IN PRIVATE HOSPITALS

The concept of Total Quality Management (TQM) [28] in hospitals can be related to the generation of quality of curative, preventive, and supportive services. TQM focuses on the culture of an organisation to satisfy the customers in totality and in the hospitals it is related to the satisfaction of patients. An integrated system of tools, techniques, education and training facilities makes possible a complete change in the system of generating and offering services.

The concept of TQM in Indian hospitals, though of a recent origin, is gaining momentum. Costs in the healthcare sector have increased significantly throughout the past 25 years, and this trend is expected to continue. More than 50 % of these costs arise in hospitals. In order to control cost, fundamental changes in the healthcare sector are taking place. One promising management approach focusing on the customer and the continuous improvement of the structure, the process, and the outcome is Total Quality Management (TQM).

Perhaps the most important innovation in quality improvement has been the increased focus on system-related problems. Continuous Quality Improvement (CQl) and Total Quality Management (TQM) programs have demonstrated the importance of examining multiple steps in the process of delivering.

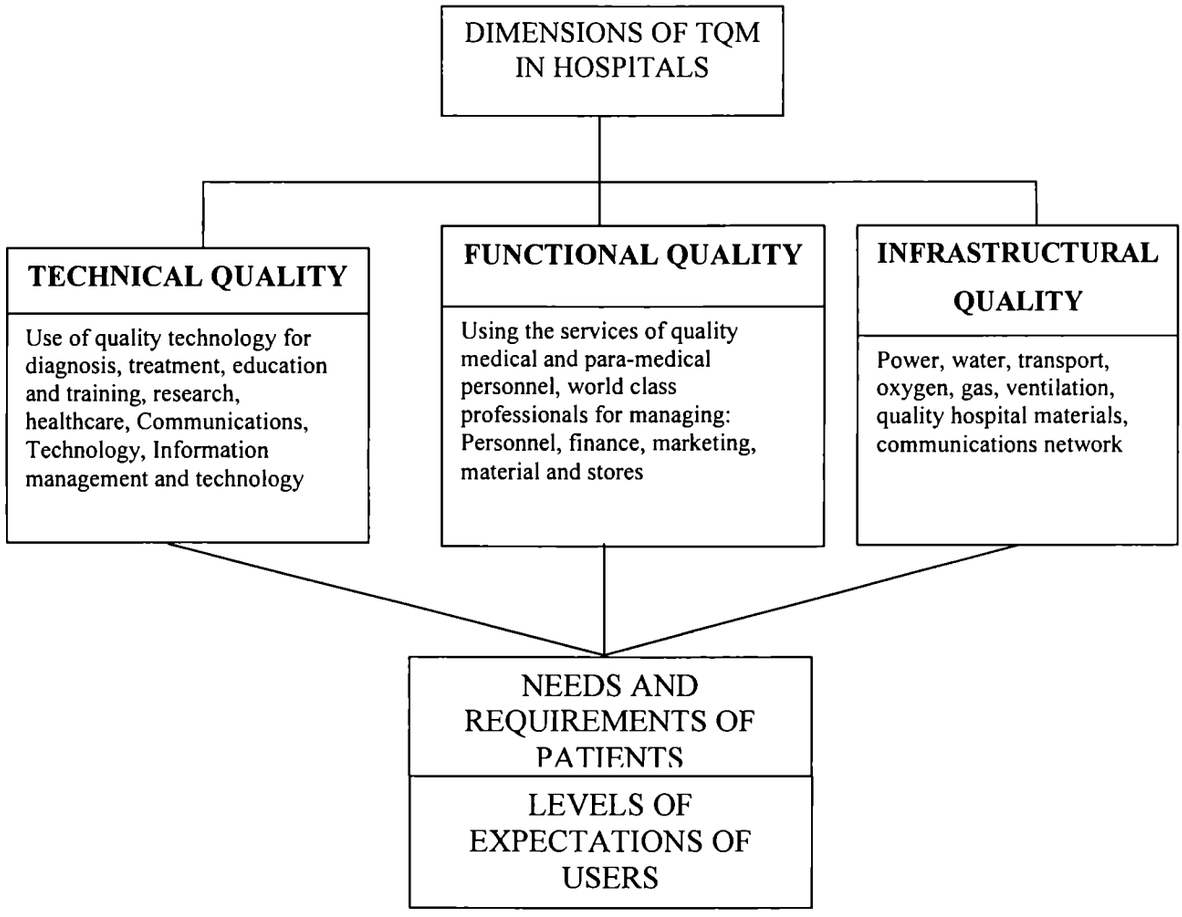
One starting point for quality improvement programs may be to examine the factors contributing to errors in processes or outcomes of care. For example, an assessment of factors contributing to errors in an intensive care unit found that human error was a factor in 55 per cent of incidents and that violations of standard practices

were a factor in 28 per cent[29]. Both direct observation and monitoring systems were used to detect errors. A prospective observational study of the causes of adverse events in the hospital found that about 18 per cent of patients experienced an adverse event and that 38 per cent of these were caused by an individual, 16 per cent were the result of systems factors, and 10 per cent were due to administrative decisions[30].

The perception of TQM makes it clear that in the hospital services for total quality management, it is essential that a fair blending of technical quality, functional quality and infrastructural quality is possible. While blending, the hospital managers bear the responsibility of identifying the changing needs and requirements of patients, increasing levels of expectations of patients and making sure that the services offered by hospitals would fulfil in totality. The different dimensions of TQM are shown in Figure 4.5:

Fig.4.5

Dimensions of TQM in Hospitals



Excellence in quality in service industry is measured on the basis of technical, functional and infrastructural standards.[31]

4.8.1 Technical Quality

In an age of technology, it is quite natural to assign a lot of priority to the process of technological sophistication; because even in hospitals, all the services are directly or indirectly influenced by technology. The modern devices of diagnosis,

treatment and education and training facilities are substantially influenced by different types of instruments, equipment, plants and information and communication technology. The technological sophistication has been successful in minimising the time gap, maximising the accuracy and bringing down the side-effects besides countering the risk factors. With the help of sophisticated equipment and plants, the results of diagnosis are found authentic. The processes of operating different organs of body, grafting, laser devices, etc. have made possible qualitative improvements in the medicare services.

4.8.2 Functional Quality

Functional quality is related to improving the functional areas of managing hospitals. The first and foremost area of operation is the performance of medical and para-medical personnel. It is essential that excellent doctors, nurses and para-medical staff are made available to hospitals.

4.8.3 Infrastructural Quality

Quality medicare services can be delivered only when the infrastructural qualities are looked into. Sophisticated technologies, quality medical and para-medical personnel, availability of power, water, and communication services, gas, oxygen, transportation, etc. play an incremental role.

The perception of TQM focuses the attention on the level of satisfaction and the hospital managers are required to be sure that the patients and the attendants using the services of the hospital are satisfied. For the success of such a programme study of needs and requirements of the patients and levels of expectation are imperative.

4.9 HOSPITAL INFORMATION SYSTEM

A Hospital Information System (HIS)[32], also called Clinical Information System (CIS) is a comprehensive, integrated information system designed to manage the administrative, financial and clinical aspects of a hospital. This encompasses paper-based information processing as well as data processing machines.

As an area of medical informatics, the aim of an HIS is to achieve the best possible support of patient care and administration by electronic data processing.

It can be composed of one or a few software components with specific extensions as well as of a large variety of sub-systems in medical specialties (e.g., Laboratory Information System, Radiology Information System). The Hospital Information System is to manage the information related to the developments and workings of hospitals either manually or with the support of sophisticated information technology. It is a device to help hospitals in the formulation of policies, setting of objectives, scheduling of the order of priorities and formulation of strategic decisions for plan implementation and evaluation.

Hospitals need different types of information for different purposes and departments. The doctors performing the role of a clinician need information related to diagnostic services and other data made available by nurses and other staff. The management of shifting of doctors and para-medical personnel can be made scientific with the help of hospital information system. The hospital managers need information about patient data on the basis of clinical investigation and about the pressure of work on the different categories of hospital personnel. Besides, the financial information

would help the managers in managing finance. Information of all concerned problems are required for planning, budgeting and controlling. They need information related to the pay-roll, work distribution and transfer. The inventory of drugs, linen, other supplies of important materials, blood, etc, are significant to hospitals and management information system helps in their proper tracking.

For improving the quality of core services, it is pertinent that modern diagnostic and treatment facilities are available. The surgical equipment of new generation sophisticated machines and instruments, internet operation and information play an important role in improving the quality of healthcare services.

4.10 CONCLUSION

Hospitals should try to establish cordial, equitable and mutually profitable relations between themselves and the beneficiaries. The hospital today is more than the combination of medical and therapeutic treatment by specialists. It undoubtedly includes a different dimension-the human and social dimension-without which it becomes difficult to thrive. The patient unquestionably is the focus of all healthcare personnel.

While doctors, nurses, hospital attendants, technologists, clinical assistants and pharmacists are directly involved in providing OP and ward care, administration, public relations, security, catering, laundry, electronics, civil, electrical and air conditioning maintenance are involved in supporting the former for providing safe healthcare. Planning needs to be done for all these personnel and not only for the direct care givers.

According to K.G. Agarwal, "Hospital effectiveness which can be measured in terms of patient satisfaction does not depend on the improvement of hospital service aspect alone but on the medical care aspect also. Hospital effectiveness has a positive association with the hospital social system. The hospital social system is almost the measure of the organisational health." [33] A proper integration among the various departments can ensure an effective hospital social system.

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Chapter V

HUMAN RESOURCE MANAGEMENT PRACTICES IN THE PRIVATE HOSPITALS IN KERALA

CONTENTS

CHAPTER V

HUMAN RESOURCE MANAGEMENT PRACTICES IN THE PRIVATE HOSPITALS IN KERALA

INTRODUCTION

The literature survey revealed the existence of many human resource problems in private hospitals, viz. high attrition, absenteeism and more specifically turnover. The present study is an attempt to find out the human resource management practices prevalent in the private hospitals in Kerala with the purpose of suggesting improvements, if necessary.

Hospital is an institution dedicated to the attention of human suffering, treatment of ailments and promotion of general health of the community. The people who are directly involved in this exercise basically include doctors and nurses with support from para-medical staff. It is the responsibility of the managements of hospitals to provide due attention to them and thereby inculcate a sense of commitment. Time has come for hospitals to adopt human resource management practices as part of hospital management due to the following reasons:

1. The increasing size of hospitals is making it impossible to have a continuance of employer-employee relationships in which they worked side-by-side, knew each other and understood mutual problems. Though there are supervisors in every department to act as a link between the management and employees, their job focuses more on getting work done. The supervisors lack training in

building human relationships, which makes human resource management practices inevitable.

2. The increasing complexity of the various problems in dealing with hospital-employee relation's demands attention of specially trained professionals. Only these professionals can assure continued attention to ensure a desirable working relationship in hospitals.
3. Proper human resource management practices in hospitals can result in enhanced job satisfaction, which would otherwise lead to high rates of attrition.
4. Proper employee selection, training and control play a vital role in bringing economy and efficiency in the functioning of hospitals. Employee selection, training and control require special skills, time and effort which cannot usually be provided by a person in charge of general administration as is the case in many hospitals.

These factors acquire even more significance since hospital personnel interact with other individuals. Generally hospital personnel interact with four groups of people: management, medical staff, patients and visitors. The interactions with each of the four groups involve a wide range of interpersonal relationships. Unless these relationships are positive, it can produce a serious impact on the functioning of the hospital.

Human resource management practices have always been performed in hospitals. Recruitment, selection, induction, training, confirmation and dismissal are the present- day activities of human resource department in hospitals, though done

more as part of administration. But it is very important that in a period of rising costs and shortage of trained hospital employees, every possible step be taken to reduce employee turnover. Good human resource practices can produce better results through employees who are well selected, thoroughly trained and work under satisfactory working conditions.

This chapter explains the analysis and interpretation of data on human resource management practices, collected from managements of 46 private hospitals in Kerala under three types of managements: corporate, mission-run and societies/trusts.

5.1 HUMAN RESOURCE DEPARTMENT

Hospitals require personnel with different categories of multi-disciplinary expertise and excellence. The doctors, para-medical staff, nursing staff, and staff of managerial cadre play an important role in offering healthcare services. So it is essential that hospitals and healthcare institutions have an efficient human resource department.

Table 5.1

Human Resource Departments in Private Hospitals

Nature of Ownership	Human Resource Department		Total
	Yes	No	
Corporate (No. & %)	10 (100%)	0 (0)	**10 (100%)**
Mission-run (No. & %)	8 (53.33%)	7 (46.66%)	**15 (100%)**
Societies & Trusts (No. & %)	6 (28.58%)	15 (71.42%)	**21 (100%)**
Total (No. & %)	**24 (52.17%)**	**22 (47.83%)**	**46 (100%)**

Source: Field Survey

Table 5.1 shows that all corporate hospitals studied have a human resource department. This practice is less prevalent in hospitals run by societies and trusts.

In mission-run hospitals and hospitals managed by societies and trusts, all activities of an HR department are carried on by the hospital administrator or manager. The various activities like recruitment, selection, training, compensation, motivation, etc are to be handled systematically and scientifically. The present system of considering human resource activity as part of hospital administration is a concept of yesteryears. Today for efficient functioning of any hospital, the employees have to treated humanely, motivated very well and morale boosted so that they remain to be associated with the hospital for longer years.

5.2 DECISION-MAKING PRACTICES

Decision-making is defined as the choice from among alternatives of a course of action; it is at the core of planning.[1] Decision-making in human resource management assumes great importance since the management can plan the future course of action on all aspects affecting employees well in advance. This facilitates employee satisfaction and their unrest can be curbed.

Decision-making could be centralised or decentralised. In a centralised decision making for human resources, the management would perform all the human resource activities at a central office for the whole hospital or even for the whole group of hospitals. Different departments do decentralised decision-making for human resource activities and the important areas covered would be on recruitment and selection process, training and dismissal policies. These types of decisions are

undertaken for nurses, para-medical staff, office staff and other lower level employees.

The type of decision-making in private hospitals under different forms of managements is given in Table 5.2:

Table 5.2

Decision-making Practices in Private Hospitals

Nature of Ownership	Types of Decision-making		Total
	Centralised	Decentralised	
Corporate (No. & %)	10 (100%)	0 (0)	**10 (100%)**
Mission-run (No. & %)	10 (66.67%)	5 (33.33%)	**15 (100%)**
Societies & Trusts (No. & %)	15 (71.42%)	6 (28.58%)	**21 (100%)**
Total (No. & %)	**35 (76.08%)**	**11 (23.91%)**	**46 (100%)**

Source: Field Survey

It is seen from Table 5.2 that decision-making process is centralised in all the hospitals under corporate management (100%). Majority of the mission-run hospitals (67%) and hospitals managed by societies and trusts (71%) also follow centralised decision-making. Since decision-making is centralised in the majority of hospitals, interdepartmental transfers of personnel other than doctors become easy. Unutilised manpower can be properly reallocated to ensure the optimum utilisation of available resources. Since the study is on managing human resource and issues relating to their retention, centralised decision-making would assist the top management to understand the employee-related problems of all departments. Common human resource policies

could be implemented from the focal point of centralised decision-making, namely the Board of Directors or the team of management representatives.

5.3 RECRUITMENT PRACTICES

Recruitment is the process of searching for prospective employees and stimulating them to apply for jobs in the organisation.[2] The objective of recruitment is to increase the selection ratio, i.e. the number of applicants per job-opening. To initiate recruitment activity, proper personnel planning must be conducted. A personnel planning is the process of deciding what positions the firm will have to fill and how to fill them.[3] The Personnel Requisition Form (PRF) sets the stage for hiring different types of employees for their respective departments. Each head of the department, in consultation with the head nurse or matron as the case may be, prepares the requisition taking into consideration the probable resignations, bond period completion, leaves, etc. The requisition, as it is commonly called, is an indicator to the top management to initiate actions for advertising and filling all the required positions.

Two factors are generally considered while planning for recruitment – workload and hospital expansion. These factors were analysed for the three different types of hospitals namely corporate, mission-run and hospitals managed by societies and trusts. The details of the analysis are given in Table 5.3:

Table 5.3

Factors for Recruitment in Private Hospitals in Kerala

Nature of Ownership	Factors for Recruitment		Total
	Workload	Hospital expansion	
Corporate	4 (40%)	6 (60%)	**10 (100%)**
Mission-run	10 (66.66%)	5 (33.33%)	**15 (100%)**
Societies & Trusts	11 (35.48%)	20 (64.52%)	**31 (100%)**

Source: Field Survey

Hospital expansion is considered as the criterion for recruitment by 60% of hospitals under corporate managements. Mission-run hospitals recruit employees to meet the excess workload (66.66%) and for hospitals managed by societies and trusts the basis for recruitment is hospital expansion (64.52%). The corporate hospitals and hospitals managed by trusts and societies tap the great potential of providing quality healthcare to the public through expanding or even creating different departments. Mission-run hospitals, all more than 30 years old, already have the basic departments and hence recruit personnel only for workload, which arises when existing employees leave.

5.4 CRITERIA FOR SELECTION: QUALIFICATION AND EXPERIENCE

With many medical, nursing and pharmacy colleges producing many professionals in the respective areas, there will be a pool of applicants once an advertisement appears in any medium. Selecting the right employee becomes very

cumbersome. Still proper selection becomes very important due to the following reasons:

1. Employees with right skill and attributes will perform more efficiently.
2. Recruitment itself is very expensive, keeping in mind the high advertisement costs. Therefore selection must be made judiciously, so that a similar exercise should not be repeated in the near future.

In a hospital, qualification is the prime concern especially for doctors, nurses, para-medical staff and pharmacists. They must necessarily possess their registration numbers with their respective professional bodies. The criteria for selection of personnel in private hospitals were found out and analysed and the details are given in Table 5.4:

Table 5.4

Selection Criteria: Responses from the Managements of Private Hospitals

Nature of Ownership		Basis for Selection			
		Educational qualification	**Experience**	**Education & experience**	**Reference**
Corporate	**Always**	3 (30%)	5 (50%)	10 (100%)	1 (10%)
	Sometimes	6 (60%)	5 (50%)	0	9 (90%)
	Never	1 (10%)	0	0	0
Mission-run	**Always**	9 (60%)	11 (73.33%)	15 (100%)	11 (73.33%)
	Sometimes	4 (26.6%)	4 (26.67%)	0	4 (26.6%)
	Never	2 (13.34%)	0	0	0
Societies &Trusts	**Always**	10 (47.62%)	13 (71.40%)	16 (76.2)	15 (71.42%)
	Sometimes	10 (47.62%)	8 (38.09)	5 (23.8)	6 (28.57%)
	Never	1 (4.76)	0	0	0

ɹurce: Field Survey

As per Table 5.4, majority of the hospitals make the selection of their clinical and non-clinical staff on the basis of both educational qualification and experience. Almost 60 per cent of them always count on experience in the process of selection of candidates. It is also seen that 77.50 per cent of the hospitals sometimes rely on educational qualification and experience for selection of candidates. One unique

feature to be noticed here is that corporate hospitals do not entertain reference as a criterion for employee selection, while in hospitals managed by societies and trusts, there is a substantial role for reference.

5.4.1 Selection Criteria for Doctors

The staff selection criteria resorted to by the managements in the selection of doctors are given in Table 5.5:

Table 5.5

The Selection Criteria for Doctors Adopted by Private Hospitals

Nature of Ownership	Criteria						
	Marks	**Experience**	**Marks & experience**	**Reference**	**Marks, experience and reference**	**Community**	**Community, marks, experience and reference**
Corporate (10)	0	3 (30%)	10 (100%)	3 (30%)	10 (100%)	0	0
Mission-run (15)	0	6 (40%)	7 (46.63%)	5 (33.33%)	12 (80%)	0	15 (100%)
Societies & Trusts (21)	0	6 (28.57%)	16 (76.19%)	10 (47.61%)	18 (85.71%)	2 (9.52%)	1 (4.76 %)
Total	**0 (0)**	**15 (32.60%)**	**33 (71%)**	**18 (39.13%)**	**40 (89.13%)**	**2 (9.52%)**	**16 (37.48)**

Source: Field Survey

Table 5.5 shows that none of the hospitals (89.13%) studied considers marks as the only criterion for selection of doctors. Marks coupled with experience or reference mattered most. Corporate hospitals did not consider any community also as a criterion for selection of doctors. An interesting fact is that only mission-run hospitals consider 'community' along with other factors like marks and experience.

Thus quality of the candidate plays an important role in the selection of doctors in hospitals.

5.4.2 Selection Criteria for Nurses

The staff selection criteria adopted to by the managements in the selection of nurses are given in Table 5.6.

Table 5.6

The Selection Criteria for Nurses Adopted by Private Hospitals

Nature of Ownership	Criteria						
	Marks	**Experience**	**Marks & experience**	**Reference**	**Marks, experience and reference**	**Community**	**Community, marks, experience and reference**
Corporate (10)	7 (70%)	9 (90.00%)	10 (100%)	-	10 (100%)	-	-
Mission-run (15)	5 (33.33%)	12 (80%)	12 (80%)	-	15 (100%)	12 (80%)	12 (80%)
Societies & Trusts (21)	7 (33.33%)	9 (42.85%)	8 (38.09%)	5 (23.8%)	21 (100%)	5 (23.80)	21 (100%)
Total (46)	**19 (41.30%)**	**30 (65.21%)**	**30 (65.21%)**	**5 (23.8%)**	**46 (100%)**	**17 (36.95%)**	**33 (71.74%)**

Source: Field Survey

Table 5.6 shows that in the selection of nurses, 100 per cent of private hospitals studied give priority to marks, experience and reference of the candidate. Eighty per cent of the mission-run hospitals consider experience as a major factor for selecting nurses. Community is also considered as a factor for nurses in the case of mission-run hospitals. Hospitals managed by societies and trusts also considered community, provided they possessed marks and experience also.

5.4.3 Selection Criteria for Para-medical staff

For this study, para- medical staff include the lab technicians, pharmacists and x-ray machine operators. Their selection criteria are also of utmost importance since any negligence from their side could lead to medical errors. In fact the doctors rely on reports approved by them. The selection criteria of para-medical staff adopted by hospitals under study are given in Table 5.7:

Table 5.7

The Selection Criteria for Para-medical Staff Adopted by Private Hospitals in Kerala

Nature of Ownership	Criteria						
	Marks	**Experience**	**Marks & experience**	**Reference**	**Marks, experience and reference**	**Community**	**Community, marks, experience & reference**
Corporate (10)	0	2 (20%)	8 (80%)	0	10 (100%)	0	0
Mission-run (15)	5 (33.33%)	5 (33.33%)	10 (66.67%)	5 (33.33%)	10 (66.67%)	11 (73.33)	15 (100%)
Societies & Trusts (21)	7 (33.33%)	11 (52.38%)	10 (47.61%)	5 (23.8%)	12 (57.14%)	12 (57.14%)	21 (100%)
Total (46)	**12 (26.08%)**	**18 (39.13%)**	**28 (60.86%)**	**10 (21.74%)**	**32 (69.56%)**	**23 (50%)**	**36 (78.26%)**

Source: Field Survey

Table 5.7 shows that hospitals under different managements consider marks, experience and reference as major criteria for recruitment of para-medical staff also.

The above analysis clearly shows that quality of para-medical staff is provided utmost importance in private hospitals and their selection is also on merit.

5.5 MODE OF COMMUNICATION

There are two main forms of communication: External and Internal. Both are vital to the success of any organisation, here being hospital.

5.5.1 External Communication

External operational communication is that part of an organisation's structured communication with people outside the organisation in an effort to accomplish certain objective. External communication in human resource management includes basically employment advertisements and offer/appointment letters.

The responses of managers on the aspect of appointment letters to the staff while joining are given in Table 5.8:

Table 5.8

Appointment Letters to Staff of Private Hospitals in Kerala

Nature of Ownership	Issuance of appointment letters		Total
	Yes	No	
Corporate (No. & %)	8 (80%)	2 (20%)	**10 (100%)**
Mission-run (No. & %)	8 (53.33%)	7 (46.67%)	**15 (100%)**
Society & Trusts (No. & %)	9 (42.85%)	12 (57.14%)	**21 (100%)**
Total (No. & %)	**25 (60.97%)**	**21 (45.65%)**	**46 (100%)**

Source: Field Survey

It is evident from Table 5.8 that majority of the corporate hospitals issue appointment letters to their staff at the time of their joining itself though it is not similar in the other two types of private hospitals. In corporate hospitals, appointment letters are provided to all permanent employees, irrespective of job category.

In mission-run and hospitals managed by societies and trusts, permanent employees of the categories of junior nurses and below are provided the joining letters only on request. The reason cited was that if appointment letters are issued in advance of joining, they would use the same to bargain with other hospitals.

It is also true that since all these hospitals have training schools attached to them as part of the admission agreement of the nursing school, the students are required to fulfil the bond period. All nursing schools insist on a bond where in every student is expected to work in the same hospital for a stipulated period of time after completion of the course. Such bonded staff remains in the hospital for gaining experience. But for this study data was collected only for permanent employees.

5.5.1.1 Contents of Appointment Letter

An appointment letter must necessarily contain the name of the employee, designation, salary agreed upon, job description, etc. Definitely it must contain salary details and job description.

The details of the content of the appointment letter were elicited from the respondents. The data and results of the analysis done in this regard are given in Table 5.9:

Table 5.9

Contents of Appointment Letters

Nature of Ownership	Contents of appointment letters	
	Salary details	**Job description**
Corporate (No. & %)	8 (80%)	10 (100%)
Mission-run (No. & %)	8 (53.33%)	10 (66.67%)
Society &Trusts (No. & %)	9 (42.85%)	12 (57.14%)

Source: Field Survey

Table 5.9 reveals that appointment letters issued by majority of corporate hospitals contain salary details (80%) and job description (100%). The point to be noted here is that all the hospitals do not always specify the salary payable to their employees. Also the employees are not sure about their specific jobs since it is not mentioned in the appointment letter. It is essential that all appointment letters carry salary and job description details. Thus the employees can know for sure the types of job to be performed. This reinforces the confidence of employees, which, in turn, will help them to work more efficiently.

5.5.2 Internal Operational Communication

Internal operational communication consists of structured communication within an organisation pertaining to the accomplishing work goals.[4] The management may use memos, circulars, letters or notice boards as the medium of communication and employees may use exit interviews, suggestion boxes or grievance cells as their medium.

5.5.2.1 Internal Operational Communication by Management

The details of the communication channels used by management for communicating messages to employees are given in Table 5.10:

Table 5.10

Internal Communication Channels used by Private Hospital Managements

Communication Channels	No. & %
Memos/Circulars	22(47.83%)
Notice board	10(21.74%)
Letters	12(36.08%)
Others	2(4.38%)
Total	**46(100%)**

Source: Field Survey

It is evident from Table 5.10 that 48% hospitals studied depend on memos/circulars for communicating with employees and 36 per cent through letters. Wherever matters had to be conveyed individually, the management used letters and issues on common human resource management were conveyed through circulars.

5.5.2.2 Internal Operational Communication by Employees

The commonly accepted communication channels used by the employees were also found out from the management. The details are given in Table 5.11:

Table 5.11

Communication Channels used by Employees

Communication Channels	No. & %
Suggestion box	8(17.40%)
Exit interview	23(50%)
Surveys	4(8.70%)
Grievance procedure	11(23.90%)
Total	**46 (100%)**

Source: Field Survey

Table 5.11 shows that for 50 per cent of the respondents, the major communication channel of the employee is exit interview. Suggestion box is considered by 17.4 per cent of the respondents to communicate to their employers. Grievance procedure is also an accepted channel of communication used by employees through the grievance cell existing in hospitals.

5.6 AWARENESS OF PERSONNEL POLICIES

Personnel policies refer to the principles and rules of conduct that employees need to follow. Hospital shifts, shift timings, overtime, leave availing procedures, holidays, and details of termination of service, etc form part of hospital personnel policies. In order that transparency exists in hospitals, these policies must be made known to the employees.

The responses of the management on whether all the personnel policies are made known to the employees in writing are given in Table 5.12:

Table 5.12

Awareness of Personnel Policies among Staff in Private Hospitals

Nature of Ownership	Responses		Total
	Yes	No	
Corporate (No. & %)	2 (20%)	8 (80%)	**10 (100%)**
Mission-run (No. & %)	5 (33.33%)	10 (66.66%)	**15 (100%)**
Society &Trusts (No. & %)	10 (47.61%)	11 (52.38%)	**21 (100%)**

Source: Field Survey

Table 5.12 shows that majority of the hospitals under the three forms of managements do not make all the personnel policies known to the employees in writing. Hence, employees are kept in the dark about various benefits, claims, leaves, etc. The hospitals managed by societies and trusts seem to be more employee-friendly in this context since at least 47.61% of the hospitals inform the hospital human resource policies.

5.7 CAPACITY BUILDING PROCESS

Capacity Building is the process of equipping individuals with the understanding, skills and access to information, knowledge and training that enable them to perform effectively. Capacity building is defined as the "process of developing and strengthening the skills, instincts, abilities, processes and resources that organizations and communities need to survive, adapt, and thrive in the fast-changing world."[5]

5.7.1 Capacity Bı ilding Process: Induction Programme

Induction is . technique by which a new employee is rehabilitated into his surroundings and ıtroduced to the practices, policies and purposes of the organisation.[6] This ; a welcoming process which is conducted only once for each employee, during w ıich the employee is informed about the policies and procedures existing in the hosp tal. Induction is provided to nurses, para-medical staff and other staffs by the head nurse or by the hospital administrator. In the case of doctors induction the respe tive heads of departments conducts programme. Without a proper induction, employ(es, especially fresh recruits, will feel insecure and nervous since they are new to a work environment. At the same time, if done properly, induction provides confiden(e to the new recruits.

The respo ıses of the management on whether induction programmes are conducted or not a re given in Table 5.13:

Table 5.13

Inductı(n Programmes: Responses from Hospital Managements

Nature o1 Ownershi ı	Responses			Total
	Always (No. & %)	Sometimes (No. & %)	Never (No. & %)	
Corporate	7(70.00%)	1(10.00%)	2(20%)	10(100%)
Mission-ru ı	11(73.33%)	3(20%)	1(6.66%)	15(100%)
Societies & Trusts	15(71.42%)	4(19.04%)	2(9.52%)	21(100%)

Source: Field Survey

Table 5.13 shows that majority of the hospitals under the three different management groups always conduct orientation programmes for their new recruits. The department heads in case of doctors and nursing superintendents in case of nurses and auxiliary staff does these orientation programmes.

This is a positive approach of the private hospitals since the employees become more confident to work in such environments. This confidence will help them work more efficiently without any ambiguity.

5.7.2 Capacity Building Process: In-house Training Programme

Training is an application of knowledge. Since we find multi-dimensional changes in the medical sciences in addition to the changes in the behaviour profile of patients and their relatives, it is essential that training in related disciplines are imparted to all categories of hospital personnel.[7] Medical technology is advancing, so are the diseases. Different types of communicable and non-communicable diseases change the disease profile of patients. Thus, training has become an indispensable element in the medical field.

The responses of management on training policies in private hospitals are given in Table 5.14:

Table 5.14

In-house Training Policies of Private Hospitals

Nature of Ownership	Responses		Total
	Yes	No	
Corporate (No. & %)	10 100%)	0	**10 (100%)**
Mission-run (No. & %)	11 (73.33%)	4 (26.67%)	**15 (100%)**
Trust (No. & %)	12 (57.14%)	9 (47.85%)	**21 (100%)**
Total (No. & %)	**33 (71.74%)**	**13 (28.26%)**	**46 (100%)**

Source: Field Survey

It can be seen from Table 5.14 that majority of hospitals under study have their own training policies. Since all these hospitals have a nursing school attached to the main hospital, training is provided to most of the nurses and para-medical staff. Hospitals usually conduct various programmes on health like nursing courses of different durations usually with in-house faculty. Some hospitals have consultants coming from other states and doctors receive hands-on experience while working with them.

5.7.3 Capacity Building Process: External Training programmes

Since all the hospitals surveyed had nursing schools, internal training programmes were available to a certain extent. But hospital personnel must be deputed to attend training programmes outside the hospital also. Various professional bodies like Indian Medical Association, Paediatrics Society, Oncology Society of

India, etc. conducts short-term training programmes at their nodal centres by experienced professionals.

The details of the personnel sent for training as reported by the respondents are given in Table 5.15:

Table 5.15

Personnel sent for External Training Programmes

Category	Responses		Total
	Yes No. & %	No No. & %	
Doctors	18(39.13%)	28(60.87%)	46(100%)
Nurses	22(47.82%)	24(52.18)	46(100%)
Para-medical staff	3(6.52)	43(93.48%)	46(100%)

Source: Field Survey

Table 5.15 shows that out of 46 hospitals only 18 are interested in sending doctors for training. It was noticed that private hospitals, as a practice, do not have a system of sending doctors for training unless he/she is a stakeholder in the hospital since training for doctors is very expensive.

Out of 46 hospitals, 22 sent nurses for training. Also the training policy for para-medical staff is not encouraging. In all the three categories of employees, majority are not sent externally to attend any training programmes. This is not an encouraging trend, especially when medical technology is advancing at a very high rate. Reasons suggested for this approach was shortage of people. Training takes away lot of man-hours at the hospitals putting the patients in a fix.

Majority of the hospitals are imparting training for employees only once a year. Since the Indian Medical Council stipulates that doctors and nurses should be trained on a regular basis, the management must be more concerned and must try to adhere to such norms.

5.7.4 Capacity Building Process: Post-Training appraisal

Equally important as training is post-training appraisal. This is done to determine the effectiveness of the training programme – to understand if employees who were sent for training benefited from such programmes. The details of the post-training appraisal conducted by hospitals are given in Table 5.16:

Table 5.16

Post-training Appraisal conducted by Private Hospitals

Nature of Ownership	Responses		Total
	Yes	No	
Corporate (No. & %)	6 (60%)	4 (40%)	**10 (100%)**
Mission-run (No. & %)	6 (40%)	9 (60%)	**15 (100%)**
Societies &Trusts (No. & %)	2 (9.53%)	19 (90.47%)	**21 (100%)**
Total (No. & %)	**14 (30.43%)**	**32 (69.56%)**	**46 (100%)**

Source: Field Survey

It can be seen from Table 5.16 that majority of the hospitals managed by trusts (90.47%) do not conduct a post-training appraisal for their employees. Thus the effectiveness of the training programmes conducted is never verified. But 60% of corporate hospitals have a system of conducting post-training appraisal.

5.7.5 Capacity Building Process: Implement New Skills

The frequency of permission granted to trained staff to administer the new skills acquired by them through training received was elicited next. Such instances increase the confidence of employees and boost their morale. The details of the analysis are given in Table 5.17:

Table 5.17

Post-Training Skill Implementation

Nature of Ownership	Responses			Total
	Always	Sometimes	Never	
Corporate (No. & %)	5 (50%)	3 (30%)	1 (10%)	**10 (100%)**
Mission-run (No. & %)	11 (73.33%)	-	4 (26.67%)	**15 (100%)**
Societies &Trusts (No. & %)	9 (42.86%)	6 (28.57%)	6 (28.57%)	**21 (100%)**
Total (No. & %)	**25 (54.34%)**	**9 (21.95%)**	**11 (23.91%)**	**46 (100%)**

Source: Field Survey

Majority of the mission-run hospitals (73.33%) and 50 per cent of the corporate hospitals always permit their trained staff to administer new skills acquired through training. Hospitals managed by trusts (42.86%) are also in favour of permitting their employees in implementing skills learnt by them through training received from elsewhere. Usually it is seen that doctors, who go for training, are encouraged to try out similar situations in their respective hospitals.

5.7.6 Capacity Building Process: Deputing for Seminars/Conferences

Various hospitals and associations conduct seminars and conferences at local, national and international levels. Though it is not practical to depute everyone for the same, key persons in charge of every department must be deputed. This enhances their knowledge on technology innovations in medical field.

The analysis done on frequency of sending employees for seminars/ conferences is given in Table 5.18:

Table 5.18

Deputing for Seminars/Conferences

Nature of Ownership		Responses		
		Annually Once	Annually Twice	Never
Corporate (10)	D	7 (70%)	3 (30%)	-
	N	10 (100%)	-	-
	P	7 (70%)	-	3 (30%)
Mission-run (15)	D	12 (80%)	3 (20%)	
	N	10 (66.67%)	-	5 (33.34%)
	P	7 (46.67%)		8 (53.33%)
Society/Trust (21)	D	21 (100%)	-	-
	N	10 (47.61%)	-	11 (52.39%)
	P	-	-	-

Source: Field Survey D-Doctors N-Nurses P- Para-medical Staff

Table 5.18 shows that majority of the hospitals managed by societies and trusts and mission-run rarely sent their para-medical staff for seminars or conferences.

This situation arises due to under-staffing. On the contrary, corporate hospitals as a policy send majority of their employees for training. This shows a positive approach towards human resource development. Awareness about the latest practices learnt through seminars and conferences will only benefit all categories of employees personally and professionally. This will help increase the efficiency of hospitals.

5.8 PERFORMANCE APPRAISAL

Performance appraisal and review is the formal, systematic assessment of how well employees are performing their jobs in relation to established standards and the communication of that assessment to employees. Review of performance must be done at least once annually to give feedback to the employees on their strengths and weaknesses. The basic accountability for scheduling and conducting performance appraisal rests with the immediate supervisor and review is communicated by the Heads of each department.

Performance appraisal is to be meticulously followed in hospitals particularly because in hospitals people work in teams where number of people, equipments, apparatus, medicines and nursing play an important role.

5.8.1 Performance Appraisal- System

Taking into consideration the importance of performance appraisal system, it was imperative to check with the hospital managements whether this system existed in their respective hospitals. The details of existence of a formal performance appraisal system are provided in Table 5.19:

Table 5.19

Performance Appraisal System in Private Hospitals

Nature of Ownership	Responses	
	Yes	No
Corporate (No. & %)	10 (100%)	-
Mission-run (No. & %)	9 (60%)	6 (40%)
Societies &. Trust (No. & %)	13 (61.91%)	8 (38.09%)
Total (No. & %)	**32 (69.56%)**	**14 (30.44%)**

Source: Field Survey

As per Table 5.19 all hospitals under the corporate management and 60% of the mission-run and 61.91% trust hospitals have a performance appraisal system, which shows a positive trend in human resource management practices. A good performance appraisal system can help an employee in identifying his/her strengths and weaknesses. It is based on this appraisal that people are given increments, promotions and transfers.

5.8.2 Performance Appraisal – Purpose

Performance appraisals are used for a variety of purposes namely, compensation review, performance improvement, verbal feedback, documentation, promotion, training, transfer, discharge, layoff, personnel research and manpower planning.[8]

The rank order of the need for performance appraisal as revealed by the respondents is given in Table 5.20:

Table 5.20

Rank Order of Purposes of Performance Appraisal

Purposes	Rank I	Rank II	Rank III	Rank IV	Rank V
Wage/salary revision	15 (32.60%)	3 (6.52%)	8 (17.39%)	6 (13.04%)	-
Promotion	6 (13.04%)	8 (17.39%)	1 (2.17%)	6 (13.04%)	14 (30.43%)
Transfer	6 (13.04%)	4 (8.69%)	4 (8.69%)	15 (32.60%)	8 (17.39%)
Identifying training needs	11 (23.91%)	8 (17.39%)	12 (26.08%)	1 (2.17%)	-
Verbal feedback	8 (17.39%)	12 (26.26%)	4 (8.69%)	4 (8.69%)	4 (8.69%)

Source: Field Survey

Table 5.20 shows that 32.60 per cent of hospitals ranked wage/salary revision as the first use of performance appraisal and 23.91 per cent used the same for training needs identification. Verbal feedback is ranked first by 17.39 per cent of the respondents. Only 6 hospitals each gave promotion and transfer as the first use of performance appraisal. Verbal feedback is ranked by 29.26 per cent of hospitals as the second use of performance appraisal. This means that out of 46 hospitals 17.39 per cent ranked verbal feedback as the first purpose of performance appraisal, 29.26 per cent ranked second and so on.

5.8.3 Performance Appraisal – Criteria

The rank order of the criteria used in the performance appraisal of the employees is given in Table 5.21. The commonly accepted criterion used by the superiors for performance include the quality of work done, quantity of work done, job knowledge, regularity of work done and discipline at work. All elements of a performance appraisal format should be self-explanatory and easy to understand.

Table 5.21

Criteria Used for Performance Appraisal System in Private Hospitals

Criteria	Rank I	Rank II	Rank III	Rank IV	Rank V
Quantity of work	3 (6.52%)	18 (39.13%)	19 (41.30%)	-	-
Quality of work	23 (50%)	14 (30.49%)	2 (4.35%)	-	-
Job knowledge	12 (26.08%)	10 (21.74%)	11 (23.91%)	7 (15.21%)	-
Regularity at Work	25 (54.35%)	8 (17.39%)	1 (2.14%)	15 (32.60%)	14 (30.44%)
Discipline	-	6 (13.04%)	5 (10.86%)	12 (26.08%)	17 (36.96%)

Source: Field Survey

Table 5.21 shows that only 6.52 per cent of the respondents ranked quantity of work done as the prime criterion, while 54.35 per cent consider regularity at work as the prime criterion for performance appraisal. Thus a person who takes less leave and is regular at work is ranked highest. Quality of work is ranked first by 50 per cent of the respondents as the criterion for performance appraisal.

The management representatives were permitted to rank one or more factors for the same rank since some hospitals considered them to be overlapping. Hence, more than one factor was ranked second.

5.9 EMPLOYEE TURNOVER

Employee turnover has been defined as 'the rate of change in the working staff of a concern during a definite period'.[9] Turnover rate is the study of separations (resignation or dismissal) divided by total employment.

Employee turnover is a major problem faced by private hospitals in Kerala. The reasons for labour turnover were also elicited from the questionnaire.

5.9.1 Employee Turnover -Causes

The responses of the management representatives were collected in this regard to the causes of employee turnover and analysis of data is given in Table 5.22:

Table 5.22

Reasons for Employee Turnover in Private Hospitals

Nature of Ownership		Factors for Employee Turnover		
		Better job prospects abroad	**Marriage**	**Better job prospects within India**
Corporate (10)	**Always**	10 (100%)	3 (30%)	6 (60%)
	Sometimes	0	3 (30%)	0
	Never	0	4 (40%)	4(40%)
Mission-run (15)	**Always**	12 (80%)	6 (40%)	9 (60%)
	Sometimes	1 (6.66%)	6 (40%)	6 (40%)
	Never	2 13.33%)	3 (20%)	0
Societies &Trusts (21)	**Always**	13 (61.9%)	11 (52.38%)	15 (71.43%)
	Sometimes	8 (38.09%)	5 (23.80%)	6 (28.57%)
	Never	0	5 (23.80)	0

Source: Field Survey

Marriage is considered as a factor when the employee leaves the hospital of first employment due to marriage. He/ she may join some other hospital in India or abroad, but the prime reason for leaving the present job is marriage.

Table 5.22 shows that employee turnover is the major factor hindering the smooth conduct of a corporate hospital. This arises due to abundant employment opportunities abroad for the doctors and nurses. Due to the adherence of selection of quality staff, they are academically and experience-wise more competent than others. This results in a situation where the staffs are lured by better salary packages abroad than any Indian hospital. Marriage has the least influence on labour turnover in corporate hospitals.

In the case of mission-run hospitals and hospitals managed by societies and trusts, employees showed a liking to join whenever they received any better offer for 'better job prospects abroad', or from 'within India'.

It was decided to test whether there existed any significant difference in the reasons for labour turnover among the three different managements of hospitals (corporate, mission-run and trusts).

5.9.2 Employee Turnover -ANOVA

One-way ANOVA test was applied and F-ratios were found out. The data and results of the analysis done are given in Table 5.23:

Table 5.23

Summary of ANOVA on Reasons for Labour Turnover cited by Management of Private Hospitals

Welfare measures	Source	Sum of Squares	df	Mean square	F value
Better job prospects abroad	Between groups	0.368	2	0.184	0.725
	Within groups	9.407	37	0.254	
	Total	9.775	39		
Marriage	Between groups	2.541	2	1.27	6.32**
	Within groups	7.434	37	0.201	
	Total	9.975	39		
Better job prospects in India	Between groups	0.171	2	8.57E-02	0.182
	Within groups	17.429	37	0.471	
	Total	17.6	39		

Source: Field Survey
** significant at 0.05 level*
F (2, 37) at 0.05 level =3.26

Table value of F
F (2, 37) at 0.01 level = 5.27

Table 5.23 shows that in case of reasons like better job prospects abroad and better job prospects in India, no significant difference was observed with respect to hospitals under different managements. But in the case of marriage as the reason for labour turnover, significant difference was observed ($F = 6.32$; $p < 0.01$) for hospitals under different managements. This shows that the hospitals under different managements differ significantly with respect to 'marriage' as the reason for labour turnover.

5.10 SALARY ADMINISTRATION

The most important problem before any management is to manage salary in an effective manner so that the employees are motivated to remain in their hospital.

Since experience matter most in hospitals, it is difficult to maintain an equitable labour-cost structure. Salary must always be in tune with the service conditions or with their potentials.

Salary is fixed for different categories of employees at different rates. Salary of the doctor is fixed taking into consideration his experience, area of specialisation, qualification, seniority etc.

Similarly nurses are paid on the basis of experience rather than on qualification, since it is very rare for nurses to go for higher degrees other than Bachelor of Science in Nursing. The other diploma courses like Junior Nurses and Mid-wifery course and Auxiliary Nurse and Mid-wifery course carry lesser value. Still, people with diploma are appointed in hospitals due to shortage of well-qualified and experienced nurses.

Para-medical Staff are technically qualified and their salary is also determined by their experience.

The general factors considered while fixing the pay scale for employees are given in Table 5.24:

Table 5.24

Fixation of Pay Scale in Private Hospitals

Nature of Ownership	Responses				
	Cost of living	**Productivity**	**Prevailing rate**	**Retention**	**Collective bargaining strength**
Corporate (No. & %)	10 (100%)	10 (100%)	10 (100%)	10 (100%)	-
Mission-run (No. & %)	11 (73.34%)	12 (80%)	15 (100%)	15 (100%)	10 (66.67%)
Societies/Trust (No. & %)	16 (76.2%)	16 (76.2%)	15 (71.42%)	21 (100%)	8 (38%)

Source: Field Survey

Table 5.24 shows that corporate hospitals consider cost of living, productivity, prevailing rates in the industry and retention practice while fixing salaries for doctors, nurses and para-medical staff. Mission–run hospitals and hospitals managed by societies/ trusts consider collective bargaining strength along with other factors since trade union exists in some of these hospitals though trade unions are consulted only for lower level employees and not for doctors, nurses or para-medical staff.

5.11 WELFARE SCHEMES

There are statutory and non-statutory welfare schemes that the hospitals need to comply with. The statutory schemes include Contributory Provident Fund, Employees State Insurance, and contributions to the Labour Welfare Board. The different labour welfare measures that motivate employees, retirement benefits for the

employees etc. were analysed with a view to gauge the extent of implementation of these measures by the private hospitals under study.

5.11.1 Welfare Schemes- Financial Incentives

The responses of the hospital managements on whether they implement financial schemes for motivating employees are given in Table 5.25:

Table 5.25

Financial Schemes for Motivating Employees of Private Hospitals

Nature of Ownership	Responses			Total
	Always	Sometimes	Never	
Corporate (No. & %)	8 (80%)	2 (20%)	0	**10 (100%)**
Mission-run (No. & %)	7 (46.67%)	3 (20%)	5 (33.33%)	**15 (100%)**
Trust (No. & %)	9 (42.85%)	5 (23.80%)	7 (33.33%)	**21 (100%)**
Total (No. & %)	**12 (26.08%)**	**14 (30.43%)**	**20 (43.47%)**	**46 (100%)**

Source: Field Survey

It is evident from Table 5.25 that majority of the corporate hospitals offer financial incentives for motivating their employees. Doctors are paid private practice allowance and senior doctors have case allowance, i.e. for every special case they attend to, they receive a special pay. Some hospitals also have a system of paying a retainer fee to doctors.

For permanent nurses and other para-medical staff, financial motivators like interest-free housing loans, washing allowances, subsidised canteen facilities, free hostel facilities for unmarried staff, and travel allowance exist.

In majority of hospitals managed by trusts and societies, there is no system of providing any financial incentive other than the statutory benefits that the hospitals have to necessarily comply with under Industrial Disputes Act, Employees State Insurance Act and The Labour Welfare Board.

5.11.2 Welfare Schemes- Non-Financial Incentives

Though financial incentives play a significant role in motivating hospital personnel, non-financial incentives also help them transform to top performers. Individual incentives like status, promotion, empowerment, recognition of work and job security go a long way in building the morale of employees. Recognition for work done is expressed through various techniques namely issuing certificates, awards, mementos, etc.

The details of the non-financial motivation schemes practised by the employers are given in Table 5.26:

Table 5.26

Non-financial Motivators of Private Hospitals in Kerala

Non-financial Motivators	No. & %
Awards	8(17.39%)
Certificates	10(21.73%)
Mementos	3(6.52%)
Awards and Certificates	23(56.09%)
Nil	2(4.34%)
Total	**46(100%)**

Source: Field Survey

Table 5.26 shows that in majority of hospitals (56.09%) awards and certificates are distributed for motivating their employees, but it is sad to note that there are hospitals that do not have any non-financial motivators as well.

In this context, it was imperative to find out whether there existed any significant difference among the managements of hospitals on the implementation of various employee welfare schemes. For this purpose, Analysis of Variance (ANOVA) was done and F-ratios were found out.

The details of the analysis done in this regard are given in Table 5.27:

Table 5.27

Summary of ANOVA of the Various Welfare Measures Adopted by Different Hospital Managements in Kerala

Welfare measures	Source	Sum of Squares	df	Mean Square	F value
Financial Motivation	Between groups	0.349	2	0.174	0.20
	Within groups	31.626	37	0.855	
	Total	31.975	39		
Non-Financial Motivation	Between groups	0.349	2	0.174	0.20
	Within groups	31.626	37	0.855	
	Total	31.975	39		

Source: Field Survey
Table value of F
F (2, 37) at 0.05 level = 3.26 *F (2, 37) at 0.01 level = 5.27*

Table 5.27 shows that the obtained F-values are not significant at any level. It clearly shows that there is no significant difference among the different hospitals classified on the basis of management (corporate, mission-run and trusts) on the

welfare measures such as financial motivators and non- financial motivators. It suggests that irrespective of the type of management of hospitals, the welfare measures for employees adopted by hospitals are not up to the expectations.

5.12 RETIREMENT POLICIES

Hospitals are complying with all the statutory benefits for permanent staff like Provident Fund, Gratuity, Employees State Insurance and contributions to State Labour Welfare Board. Since the study is confined to permanent employees, effort was made to understand what other benefits employees receive towards retirement. The retirement age is fixed at 55 years.

Every hospital has a system of appointing efficient retiring nurses on renewable annual contract basis. This ensures the retired nurses employment and saves the hospital from training costs. Such appointees leave hospital only on completion of contract period.

5.13 EMPLOYEE GRIEVANCE

The International Labour Organisation defines a grievance as 'a complaint of one or more workers in respect of wages, allowances, conditions of work and interpretation of service stipulations covering such areas as overtime, leave, transfer, promotion, seniority, job assignment and termination of service.' Bethel and others have given typical examples of employees' grievances as issues concerning wages, supervision, individual advancement, working conditions and collective bargaining. [10]

The causes of grievances of different sections of the employees in hospitals, as revealed by the hospital representatives under study, are given in Table 5.28:

Table 5.28

Causes of Employee Grievances in Private Hospitals

Nature of Ownership		Responses					
		Promotion	**Increment**	**Salary**	**Facilities**	**Disciplinary**	**Leave**
Corporate (10)	**D**	7 (70%)	1 (10%)	4 (40%)	8 (80%)	8 (80%)	6(60%)
	N	3 (30%)	8 (80%)	7 (70%)	5 (50%)	5 (50%)	4 (40%)
	P	9 (90%)	8 (80%)	7 (70%)	-	-	4 (40)
Mission-run (15)	**D**	12 (80%)	1 (6.7%)	3 (20%)	12 (80%)	10 (66.7%)	10 (66.7%)
	N	10 (66.7%)	13 (86.7%)	11 (73.3%)	5 (33.3%)	10 (66.7%)	10 (66.7%)
	P	7 (46.7%)	13 (86.7%)	15 (100%)	8 (53.3%)	12 (80%)	11 (73.3%)
Society/Trust (21)	**D**	21 (100%)	4 (19%)	5 (23.9%)	20 (95.3%)	10 (47.6%)	12 (57.1%)
	N	10 (47.6%)	10 (47.6%)	18 (85.7%)	11 (52.4%)	10 (47.6%)	11 (52.4%)
	P	21 (100%)	20 (95.3%)	20 (95.3%)	18 (85.7%)	18 (85.7%)	12 (57.1%)

Source: Field Survey

Table 5.28 shows the break-up of causes of grievances among the three types of hospitals studied. Doctors' grievances are more over poor facilities provided to them- both clinical and personal- followed by disciplinary actions. Issues like late-comings even by 10 minutes, early goings, loss of pay, etc., were cited to lead to disciplinary action. Promotion is another cause of concern for doctors. Since there is

a shortage of doctors, salary was never cited as a cause for their grievance as it was always negotiated and fixed by both the parties concerned.

In the case of nurses, increment policies mattered most followed by salary as cause of grievance. The next reason for employee grievance was on facilities – clinical and personal – provided to them. They also lacked a proper course for individual advancement.

Regarding para-medical staff, majority of the respondents view their chances of promotion as almost nil. They also rated increment and salaries to be very low.

With respect to corporate hospitals the doctors are concerned with the facilities provided to them for work. The highly qualified and paid doctors find their expertise not to be able to put to use due to lack of facilities provided. Disciplinary actions become an important factor when they are treated along with the other employees of the hospital. At the same time nurses seem to have some advancement in growth in corporate hospitals. For para-medical staff, the right set of people is appointed since they had no grievance over facilities.

With respect to mission-run hospitals doctors have a major concern over promotion and facilities provided. Nurses had increment followed by salary as their causes for concern. Para-medical staffs were really concerned about the salary offered.

Similar situation was seen for hospitals managed by societies and trusts with respect to doctors. But with nurses, when in other types of hospitals, increment was cited as the major reason for employee grievance, it is salary that is the major concern here. Para-medical staff seem to be really discontented with all the factors cited.

5.13 TRADE UNIONS

The role of trade unions and the role played by them, if any, in determining the salary of employees in their respective hospitals were elicited. Table 5.29 provides the details:

Table 5.29

Role of Trade Unions in the Private Hospitals of Kerala

Nature of Ownership	Responses			Total
	Always	Sometimes	Never	
Corporate (No. & %)	1 (10%)	1 (10%)	8 (80%)	**10 (100%)**
Mission-run (No. & %)	5 (33.3%)	4 (26.7%)	6 (40%)	**15 (100%)**
Societies &Trusts (No. & %)	6 (28.6%)	5 (23.8%)	10 (47.6%)	**21 (100%)**
Total (No. & %)	**12 (26.3%)**	**10 (21.7)**	**24 (52%)**	**46 (100%)**

Source: Field Survey

As revealed by Table 5.29, in majority of the hospitals under the corporate sector (80%) there is no role for trade union in determining the wages. But in 33.3% of mission-run hospitals the trade unions have a role in determining the wages of employees. Though wage determination is confined to the lower level/ rank and more so in the case with unskilled workers like sisters and house keeping, the management and the union members had a good working relationship. It was surprising to note that some unions had political affiliations as well.

5.14 CONCLUSION

On analysing the data under employment perspectives, we find that there exists a good element of professionalism in these hospitals as is evident from the study. A centralised decision-making policy on all the human resource aspects clearly reflects the organisational structure in these hospitals. But the policy of hospitals to recruit on the basis of workload without having a manpower plan or hospital expansion shows lack of proper vision and planning. When such hospitals feel the need to recruit more people, they do so in a hurry without proper screening or even trying to balance from the nursing schools. This ad-holism in the system of recruitment leads to improper staffing of all categories of employees. The practice of giving due weightage and importance for education and experience in finally selecting doctors and other staff is positive.

Compensation is a sensitive issue over which there is a concern in every type of organisation, leave alone hospitals. But from the study it is evident that lack of facilities–both clinical and personal–is an issue of greater concern especially when promotion/career prospects are less. Hospitals must develop various systems for retaining employees. Since opportunities for promotion are very limited, management should think of various other motivational tools to retain their employees.

With no well-defined working hours and financial and non-financial motivators, it is very difficult to have a contented set of staff to work with any organisation. In such circumstances efforts must be initiated by the management to provide better welfare facilities. The F-values showed that there was no significant difference among the different hospitals on the welfare measures adopted. Irrespective

of the type of management of hospitals, the welfare measures for employees were far below their level of expectations.

The employees of the hospitals studied very rarely had political affiliations. As such there was no collective bargaining even for their benefits. This is exactly opposite to the government sector where there is an organised movement. The different political parties have a major role in deciding the working conditions, salary etc. in government hospitals.

To sum up from the management's perspective, the issues with respect to labour turnover in the private sector are only going to increase due to increased demand from European and American countries for nurses. The hospital managements must consider differential pay, overtime allowances, encashment of leave etc as retention mechanisms.

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CHAPTER VI

EMPLOYEES' PERCEPTION ON HUMAN RESOURCE MANAGEMENT PRACTICES IN PRIVATE HOSPITALS IN KERALA

CONTENTS

CHAPTER VI

EMPLOYEES' PERCEPTION ON HUMAN RESOURCE MANAGEMENT PRACTICES IN PRIVATE HOSPITALS IN KERALA

The views of the managements of private hospitals in Kerala on the human resource management practices in their respective hospitals were elicited and dealt with in detail in the fifth chapter. The study would be incomplete without evaluating the opinion of employees in these hospitals as they are the beneficiaries of HR policies adopted by management. Effort was made to identify factors influencing employee perception of human resource management practices in the different types of hospitals, namely, corporate, mission-run and trusts/societies. A detailed questionnaire, prepared keeping in mind all the relevant human resource management practices to be followed in hospitals, was used for this purpose. The questionnaire was administered to the employees of various allopathic private hospitals in Kerala under different ownerships and their observations were collected.

A Likert type questionnaire was prepared in English and Malayalam, so that the respondents could easily answer all questions. The questionnaire was distributed to more than 350 employees. However, of this, only 308 questionnaires were found to be complete in all respects. The collected data were analysed, details of which are given in the following pages.

The ownership details of the hospitals from which employee data were collected are shown in Table 6.1:

Table 6.1

Distribution of Employees Responded by Type of Ownership

Type of Ownership	No. & Percentage
Corporate	96 (31.17)
Mission-run	92 (29.87)
Trusts/Societies	120 (38.96)
Total	**308(100)**

Source: Field Survey

It can be seen from Table 6.1 that 96(31.17%) respondents are working in corporate hospitals, 92 (29.87%) in mission-run hospitals and 120 (38.96%) in hospitals owned by trusts/societies. These hospitals were chosen at random from eight out of 14 districts of Kerala. Table 6.1 is different from Table 5.1in the earlier chapter. When Table 5.1 explained human resource management from employers' perspective, Table 6.1 explains the same from employees' perspective.

The employees covered in this study include doctors, nurses and para-medical staff. A brief description of different factors considered for the study is given below:

1. Working Environment – All organisations work within an external and internal environment. These environments directly or indirectly influence his/her feelings on the job. The five main factors that internally influence the perception of employees about management are job security, opportunities for career development, meaningful work, communication--both oral and written-- and recognition.
2. Cooperation - Employees can work freely only if they are comfortable and confident about their peers and superiors. Equally important is the active support of seniors towards juniors for the development of the latter. Since seniors are more clinically experienced, their cooperation and support is of crucial importance to the juniors. Level of job satisfaction will be high if employees are helpful and trustful to each other, and there is freedom of expression. A satisfied employee rarely leaves.
3. Training Programmes - Medical technology is changing rapidly, so also medical science. Hospitals must conduct training programmes for all levels of employees. There are various types of training programmes, even leading to diploma. During the course of the study there were training programmes conducted for different levels of employees by different hospitals like blood transfusion and related issues for doctors, how to deal with HIV/AIDS and Anti Retroviral Treatment (ART) for nurses, Bio-Medical Communication for medical technologists etc. Though similar training programmes are

conducted by various hospitals and departments, the question here is 'how many employees consider these training programmes seriously?', 'how many hospitals send their employees for seminars/conferences?'

4. Performance feedback - Employees require feedback about the work performed. Employees were asked whether they received any feedback from superiors and whether there existed any counselling in hospitals for employees.
5. Favouritism - During the pilot study it was seen that many hospitals overlooked 'quality' for 'recommendation' for promotion, performance rewards of employees etc.
6. Personnel Policies - The perception employees have on the existing rules and procedures was elicited. It was important to understand whether all the employees were aware of the existing policies on suspension, dismissal etc.
7. Fairness of Pay - Salary matters first, until and unless it is a mission-run hospital and people work for charity. In majority of the cases and with majority of the levels of employment, salary that is compatible with the prevailing market is the prime concern for appointment. Questions were asked whether the experience of employees mattered in salary fixation, etc.
8. Top Management - It is the responsibility of management to ensure a conducive work environment for all levels of employees. Such an

environment requires that the management treats employees humanely, invests considerable time and money to understand their problems and aims at the development of employees.

9. Employee Turnover – Employees' unfulfilled expectations at the current job force them to seek job outside the present hospital.
10. Welfare Measures - There are statutory benefits for employees who work in hospitals like Provident Fund, ESI etc. But what other benefits does an employ enjoy?
11. Retirement Benefits - When an employee retires from work, he/she needs to know the benefits they would receive for serving that particular hospital for the stipulated time.
12. Legislative Enactments - Effort was made to identify whether the employees had working knowledge on various enactments of hospitals like Medical Council Act, Consumer Protection Act(CPA) 1986, Minimum Wages Act etc. 'Ignorentia juris non excusat' i.e. ignorance of law is no excuse. So it was imperative to know about the level of knowledge of employees about law.

Each of the above is discussed in detail below:

6.1 WORKING ENVIRONMENT

Health care workers - medical doctors, nursing staff or other support personnel - run the risk of being infected because of their working environment. Just as physical environment affects an employee mentally,

psychological environment also affects them. Studies by Angelina O. M. Chan and Yiong Huak entitled 'Influence of work environment on emotional health in healthcare sets' tried to understand the impact of the work environment on the emotional health of doctors and nurses in a general hospital in the UK. The study brought to light the prevalence of psychiatric disorder arising due to various elements in the work environment among doctors and nurses.[1]

Linda L and Olson in their study, ' Hospital Nurses' Perceptions of the Ethical Climate of Their Work Setting', suggests "a best way to measure ethical climate can help nurses understand the work setting influences on their practice and can be used to diagnose areas for organizational change as well as to evaluate effectiveness of organizational interventions." [2]

The earlier studies reinstate the importance of study on work environment. Of the five factors affecting working environment, analysis of three important factors are given below:

6.1.1 WORKING ENVIRONMENT--JOB ROTATION

Generally all types of hospitals have a good job rotation policy. This is most applicable for nurses where they are shifted from one department to another. This system provides an opportunity to the staff to learn and gain experience from different departments. The disadvantage is that since nurses are rotated/shifted to different departments they lack continuity of clinical data of patients. Still, nurses are trained in different departments, thus equipping

them well for any emergency. But this system of job rotation is not applicable for other categories of employees. Doctors are specialists in their own field and so job rotation is not prevalent among them. The situation is similar for office and paramedical staff as well. Hence the total number of respondents is different for Table 6.2.

The responses of staff on job rotation policies in hospitals are given in Table 6.2:

Table 6.2

Job Rotation Policies of Nurses in Private Hospitals

Nature of Ownership	Responses			Total	Weighted Avg Score
	No	Neutral	Yes		
Corporate (No. & %)	20 (41.70%)	6 (12.50%)	22 (45.80%)	**48 (100%)**	**0.61**
Mission-run (No. & %)	17 (37%)	3 (6.50%)	26 (56.50%)	**46 (100%)**	**0.53**
Trusts/Societies (No. & %)	18 (30%)	5 (8.30%)	37 (61.70%)	**60 (100%)**	**0.65**
Total (No. & %)	**55 (35.71%)**	**14 (9.09%)**	**85 (55.20%)**	**154 (100%)**	

Source: Field Survey

Table 6.2 states that only 42% of the employees in corporate hospitals, 37% in the mission-run hospitals and 30% in the hospitals managed by societies and trusts are unhappy with the present job rotation policies.

Job rotation must be done scientifically. A nurse must remain in a department for a minimum period of three months to learn about various cases unique to that particular department. But in reality whenever a vacancy arises in any department nurses are deputed to support the system. With such job rotations nurses would be unable to gain experience and plan their future.

6.1.2 WORKING ENVIRONMENT-- PSYCHOLOGICAL CLIMATE

Service employees are simultaneously concerned with their own and their customers' well-being. A study by Prins and Annette entitled 'Emotional intelligence and leadership in corporate management: a fortigenic perspective' tried to investigate how an employee's emotional intelligence influences psychological climate, job effect, and indices of work-related well-being in subordinates.[5] The study suggested "Psychological work climate and job effect clearly and demonstrated their significance as mediators in relation to indices of well-being at work and therefore needs careful consideration in the workplace. The results again serve to reiterate the important influence of affective experiences in the workplace."[3]

This study also tried to check the influence of the psychological climate on employees of private hospitals and the details of the same are given in Table 6.3:

Table 6.3

Psychological Climate in Private Hospitals

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	28 (29.20%)	8 (8.30%)	60 (62.50%)	**96 (100%)**	**0.72**
Mission-run (No. & %)	50 (54.30%)	6 (6.50%)	36 (39.10%)	**92 (100%)**	**0.55**
Trusts/Societies (No. & %)	26 (21.70%)	10 (8.30%)	84 (70%)	**120 (100%)**	**0.69**
Total (No. & %)	**104 (33.77%)**	**24 (7.79%)**	**180 (58.44%)**	**308 (100%)**	

Source: Field Survey

Majority of the staff under the corporate and trust-managed hospitals experience a psychological climate which is conducive for working (62.50% and 70% respectively). Such environments help employees to acquire new knowledge and skills. But in the case of mission-run hospitals 54.30% did not seem to experience a conducive work environment as experienced by their counterparts working under the other two managements.

6.1.3 WORKING ENVIRONMENT-- COMMUNICATION

When communication is effective, it tends to encourage better performance and job satisfaction. Employees usually find it difficult to address their grievances fearing punitive actions. Suggestion boxes are

provided in all hospitals and it was noticed that there was a system of using the facility by the staff, though not by doctors. Doctors consider approaching the heads of department or sometimes HR department/ hospital administrator for settling their problems. The exit interview is seen not only as a way to understand the reason(s) for an employee's departure, but also a way to identify trends, improve employee retention, ascertain levels of employee satisfaction, and reduce turnover.[4]

Since communication is the only source to inform the management about employee grievances, effort was made to identify modes of communication employees made use of.

Table 6.4

Modes of Communication

Nature of Ownership	Responses			Total	Weighted Average Score
	Suggestion Box	HR / HA*	Heads of Departments		
Corporate (No. & %)	8 (8.30%)	28 (29.20%)	60 (62.50%)	**96 (100%)**	**0.79**
Mission-run (No. & %)	50 (54.30%)	6 (6.50%)	36 (39.10%)	**92 (100%)**	**0.55**
Trusts/ Societies (No. & %)	84 (70%)	10 (8.30%)	26 (21.70%)	**120 (100%)**	**0.59**
Total (No. & %)	**142 (46.10%)**	**44 (14.28%)**	**122 (39.61%)**	**308 (100%)**	

Source: Field Survey

*HR/HA Human Resource Department/ Hospital Administrator

Table 6.4 shows a mixed response of the modes of communication used by employees of private hospitals studied. It is surprising to notice that 63% employees of corporate hospitals communicated their problems to their heads of departments and resorted to the HR department very less. This clearly brings to light two things: inefficiency of HR department in these hospitals and confidence the employees had on their superiors.

But in the mission-run hospitals and the hospitals managed by trusts and societies, employees depended upon suggestion box. This technique helps them to conceal their identity which shows their fear and lack of confidence.

6.1.4 WORKING ENVIRONMENT- ANOVA

Table 6.5

Summary of ANOVA on the Basis of 'Working Environment' by the Employees of Private Hospitals under different Ownerships

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
type	Between Groups	2.061	2	1.030	1.482	.229
	Within Groups	212.069	305	.695		
	Total	214.130	307			

Source: Field Survey
*** significant at 0.01 level*

ANOVA is concerned with identifying the differences between means of groups. ANOVA test was conducted to understand the difference in mean between three types of hospitals.

Table 6.5 showing the summary of ANOVA suggests that the factor 'working environment' is significant since the level of significance is less than 0.5. Thus we can accept the fact that the various factors under 'work environment' influence the perception of the human resource management practices in private hospitals studied.

6.2 COOPERATION

Work in hospitals cannot be done in isolation. Work in any hospital can be accomplished only through teamwork and this involves help and trust between each other. They should be helpful to each other. Employees must feel free to express their feelings and there should be transparency in the system.

6.2.1 COOPERATION-- TEAMWORK

Teamwork can improve patient safety. Everyday teams of medical professionals take important decisions and actions regarding diverse and complicated treatments that affect patients. High performing teams develop a sense of collective efficacy. An effective team self-corrects, compensates for each other and reallocates functions among the team members.[5]

Table 6.6 shows the details regarding the encouragement given to teamwork in hospitals:

Table 6.6

Team Work is Highly Encouraged

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	12 (12.50%)	4 (4.20%)	80 (83.30%)	**96 (100%)**	**0.84**
Mission-run (No. & %)	30 (32.60%)	6 (6.50%)	56 (60.90%)	**92 (100%)**	**0.68**
Trusts/Societies (No. & %)	4 (3.30%)	8 (6.70%)	108 (90%)	**120 (100%)**	**1.11**
Total (No. & %)	**46 (14.94%)**	**18 (5.84%)**	**244 (79.22%)**	**308 (100%)**	

Source: Field Survey

It can be seen from Table 6.6 that team work is highly encouraged in hospitals under the three different types of managements in hospitals. In a hospital there are the highly qualified doctors and specialists who are helped by support groups like the paramedical, administration and housekeeping workforce to effectively serve the patient. In this combination of doctors, paramedics and other workers teamwork is often critical[6]. Table 6.6 shows that 79 per cent of the staff agreed that team work is appreciated in private hospitals studied.

6.2.2 COOPERATION-- DAILY CASE-DISCUSSIONS

An extension of team work in hospitals is case-sharing. The doctors discuss each case with the support staff. In the case of surgeries the

surgeon discusses the complexity of the case with junior doctors, nurses and theatre staff. This system of communication increases the involvement of team members. A new member who joins the team later, due to shift change or as part of job rotation should also be informed about the case. Employees of private hospitals were asked whether such discussions occur in their work place and the analysis in this regard is given in Table 6.7:

Table 6.7

Daily Case-Discussions in Private Hospitals

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	16 (16.67%)	6 (6.25%)	74 (77.08%)	**96 (100%)**	**0.81**
Mission-run (No. & %)	38 (41.30%)	8 (8.70%)	46 (50%)	**92 (100%)**	**0.62**
Trusts/Societies (No. & %)	28 (23.30%)	6 (5%)	86 (71.70%)	**120 (100%)**	**0.96**
Total (No. & %)	**82 (26.62%)**	**20 (6.50%)**	**206 (66.88%)**	**308 (100%)**	

Source: Field Survey

It is evident from Table 6.7 that in majority of the corporate, mission-run and society/trust hospitals day-to-day cases are discussed openly between different levels of staff with the objective of solving them. This shows the transparency in the system followed in all types of hospitals. Medical cases differ from person to person. Just like patients, their by-standers

and relatives are very sensitive. If cases are discussed daily, progress monitored systematically and reports entered properly by the respective support groups after daily discussions, errors can be avoided. Medical errors could even be fatal. These daily discussions increase the confidence of other team members and inculcate a sense of belonging to the hospital they work with. Such satisfied employees remain in the hospitals and spread a positive culture among others.

6.2.3 COOPERATION-- MENTORING

Skill-set of the employee contributes much to his/her success and thereby to the overall efficiency of the organisation. The seniors can contribute to the development of juniors personally and professionally. The juniors can acquire competence through mentoring. The atmosphere prevailing in the private hospitals of Kerala on this aspect was probed and data collected, results of which are given in Table 6.8:

Table 6.8

Mentoring in Private Hospitals

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	82 (85.40%)	6 (6.30%)	8 (8.30%)	**96 (100%)**	**0.38**
Mission-run (No. & %)	48 (52.20%)	4 (4.30%)	40 (43.50%)	**92 (100%)**	**0.57**
Trusts/Societies (No. & %)	10 (8.30%)	8 (6.70%)	102 (85%)	**120 (100%)**	**1.07**
Total (No. & %)	**140 (45.45%)**	**18 (5.85%)**	**150 (48.70%)**	**308 (100%)**	

Source: Field Survey

Eighty five percentage of hospitals managed by trusts have a systematic mentoring policy when compared with other types of hospital. Majority of the corporate hospitals (85.40%) and mission-run hospitals (52.20%) do not give attention to this aspect, probably because of the hectic workload. It may also be due to the fact that corporate and mission-run hospitals prefer to hire only competent people.

Table 6.9

Summary of ANOVA on the Basis of 'Cooperation' by Employees of Private Hospitals under Different Ownerships

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
type	Between Groups	8.555	2	4.277	6.346	.002
	Within Groups	205.575	305	.674		
	Total	214.130	307			

Source: Field Survey

*** significant at 0.01 level*

Table 6.9 states that the mean value is less than F value. It means that the mean value is significant i.e. there is cooperation among employees of private hospitals under different forms of managements.

6.3 TRAINING PROGRAMMES

Response to whether the employees are sponsored for training and whether the employees take training seriously and try to learn from the programmes they attend is given in Table 6.10. Medical professional bodies like cardiac societies, paediatric societies etc conduct seminars annually. Training programmes are conducted by many hospitals for their own staff using in-house faculty or inviting experts from outside.

The training becomes successful only when the recipients of the programme make use of such opportunities. Hospitals should be willing to accommodate ideas of doctors and nurses in trying out new techniques and practices learnt from training.

6.3.1 TRAINING PROGRAMMES—PERCEPTION

Though training is offered by hospitals it should be accepted and perceived by employees as important. Question to the effect whether employees consider training programmes seriously provided the following results:

Table 6.10

Perception of Training Programmes by Private Hospital Employees

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	4 (8.33%)	2 (4.17%)	42 (87.50%)	**48 (100%)**	**0.43**
Mission-run (No. & %)	8 (17.40%)	4 (8.70%)	34 (73.90%)	**46 (100%)**	**0.38**
Trusts/Societies (No. & %)	10 (16.66%)	4 (6.67%)	46 (76.67%)	**60 (100%)**	**0.5**
Total (No. & %)	**22 (14.29%)**	**10 (6.49%)**	**122 (79.22%)**	**154 (100%)**	

Source: Field Survey

Table 6.10 shows that majority of the hospital staff under the three different managements consider 'sponsored training' seriously and try to learn from the programmes they attend. The training programmes are expensive and the attitude of employees in this context is appreciable.

6.3.2 TRAINING PROGRAMMES-- PRACTICE

Training becomes effective only when it is put into practice. Since training programmes are expensive, they should be made use of by implementing the system. This will increase employee acceptance and commitment to work as show below in Table 6.11:

Table 6.11

Opportunities for Trying Learnt Practices

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	30 (31.25%)	6 (6.25%)	60 (62.50%)	**96 (100%)**	**0.72**
Mission-run (No. & %)	32 (34.80%)	6 (6.50%)	54 (58.70%)	**92 (100%)**	**0.66**
Trusts/Societies (No. & %)	36 (30%)	6 (5%)	78 (65%)	**120 (100%)**	**0.91**
Total (No. & %)	**98 (31.82%)**	**18 (5.84%)**	**188 (62.34%)**	**308 (100%)**	

Source: Field Survey

Majority of the employees (62.34%) are given opportunities to try out what they have learnt from training programmes. That reflects a broader outlook of the hospital managements. Willingness by hospital managements to permit doctors and nurses to try out what they have learnt from the training programmes gives confidence to employees and staff. This attitude improves the morale of employees leading to job satisfaction.

6.4 PERFORMANCE FEEDBACK

Performance appraisal and feedback are conducted to inform the employee what the supervisor expects from the job and to better mutual understandings. Employees receive feedback from their supervising staff. This system helps employees to understand their strengths and shortcomings.

6.4.1 PERFORMANCE FEEDBACK-- COMMUNICATION

The employees were asked whether they obtained feedback about their strengths and weaknesses from the supervising staff. The responses of the employees are given in Table 6.12:

Table 6.12

Feedback from Supervising Staff

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	4 (4.20%)	8 (8.30%)	84 (87.50%)	**96 (100%)**	**0.88**
Mission-run (No. & %)	36 (39.10%)	8 (8.70%)	48 (52.20%)	**92 (100%)**	**0.63**
Trusts/Societies (No. & %)	4 (3.33%)	16 (13.33%)	100 (83.34%)	**120 (100%)**	**1.09**
Total (No. & %)	**44 (14.29%)**	**32 (10.39%)**	**232 (75.32%)**	**308 (100%)**	

Source: Field Survey

It is clear from Table 6.12 that majority of hospital employees under corporate (87.50%) and society/trust (83.34%) managements obtain feedback about their strengths and weaknesses from supervising staff, while, only 52.20% of the employees from mission-run hospitals receive the feedback about their performance. The existence of a healthy feedback system helps to understand the strengths and weaknesses of every individual. Positive criticisms can help in the development of the individual and improve efficiency of performance. When the strengths are reinforced to any employee, they gain confidence leading them to higher levels of job satisfaction.

6.4.2 PERFORMANCE FEEDBACK-- PURPOSE

In order that the feedback is fruitful, the supervisor should refer to quantified, measurable factors in evaluating performance. By encouraging the employee to discuss failings, the supervisor can understand their causes and suggest specific steps to improve them.

The employees were asked whether the performance feedback given to them were seriously taken for their development. The responses are analysed and given in Table 6.13:

Table 6.13

Utilisation of Performance Feedback

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	12 (12.50%)	4 (4.20%)	80 (83.30%)	**96 (100%)**	**0.84**
Mission-run (No. & %)	14 (15.20%)	6 (6.50%)	72 (78.30%)	**92 (100%)**	**0.78**
Trusts/Societies (No. & %)	8 (6.67%)	8 (6.67%)	104 (86.66%)	**120 (100%)**	**1.09**
Total (No. & %)	**34 (11.04%)**	**18 (5.84%)**	**256 (83.12%)**	**308 (100%)**	

Source: Field Survey

As per Table 6.13 majority of the employees under the three forms of management (corporate, mission-run and society/trusts) take the performance feedback seriously and utilise it for their development. Assessing the efficiency of employees on the basis of a well-structured performance feedback is a scientific assessment method.

6.4.3 PERFORMANCE FEEDBACK-- APPRECIATION

The employees were asked whether their good work was appreciated by the supervising staff while giving feedback. The responses are given in Table 6.14:

Table 6.14

Good Work is Appreciated

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	40 (41.67%)	6 (6.25%)	50 (52.08%)	**96 (100%)**	**0.65**
Mission-run (No. & %)	50 (54.35%)	6 (6.52%)	36 (39.13%)	**92 (100%)**	**0.55**
Trusts/Societies (No. & %)	36 (30%)	8 (6.70%)	76 (63.30%)	**120 (100%)**	**0.9**
Total (No. & %)	**126 (40.90%)**	**20 (6.50%)**	**162 (52.60%)**	**308 (100%)**	

Source: Field Survey

Employees of 52.10% of corporate and 63.30% of trust hospitals agreed that good work is appreciated in their hospitals, though the rate of appreciation is not up to the expectation that 'good work pays'. Mission-run hospitals seem to appreciate their employees less. The human resource department must definitely look into this matter to ensure that such a culture exists in these hospitals.

Table 6.15

Summary on the Basis of Providing 'Performance Feedback' to the Employees of Private Hospitals under Different Ownerships

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
type	Between Groups	1.161	2	.581	.832	.436
	Within Groups	212.968	305	.698		
	Total	214.130	307			

Source: Field Survey

*** significant at 0.01 level*

The ANOVA test stated above proves that providing performance feedback is beneficial to all employees, irrespective of which type of hospital they represent. Mean value is less than the table value. Table 6.15 shows that the obtained value is significant at 0.01 level.

6.5 FAVOURITISM

Favouritism harms workplace morale. Favouritism fosters bad feelings amongst colleagues and often creates displeasure in the department. It creates problems in areas like promotion, salary fixation etc. It is the responsibility of the human resource department to ensure that such systems do not affect the smooth functioning of any department.

6.5.1 FAVOURITISM--PROMOTION

The promotion of an employee in an organisation should be based on merit. The employees were asked whether promotion is based on the suitability of person or is it based on favouritism. The details of the analysis done in this regard are given in Table 6.16:

Table 6.16

Promotion Based on Efficiency

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	56 (58.33%)	8 (8.33%)	32 (33.34%)	**96 (100%)**	**0.54**
Mission-run (No. & %)	28 (30.40%)	4 (4.30%)	60 (65.20%)	**92 (100%)**	**0.7**
Trusts/Societies (No. & %)	40 (33.33%)	4 (3.33%)	76 (63.34%)	**120 (100%)**	**0.89**
Total (No. & %)	**124 (40.25%)**	**16 (5.20%)**	**168 (54.55%)**	**308 (100%)**	

Source: Field Survey

It is evident from Table 6.16 that in 58.30% of the corporate hospitals promotion is based on favouritism, whereas in the case of 65.20% mission-run and 63.30% of the trust-managed hospitals, it is based on the efficiency of the person. Efficiency is given due acknowledgement in the mission-run and trust hospitals.

6.5.2 FAVOURITISM--REWARDS

The acknowledgement of good work could be in the form of performance rewards. Employees were asked whether the performance rewards are based on adequate assessment of each individual or on favouritism, the details of which are given in Table 6.17:

Table 6.17

Performance Rewards are Based on Adequate Assessment

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	36 (37.50%)	6 (6.25%)	54 (56.25%)	**96 (100%)**	**0.68**
Mission-run (No. & %)	52 (56.52%)	4 (4.35%)	36 (39.13%)	**92 (100%)**	**0.54**
Trusts/Societies (No. & %)	60 (50%)	12 (10%)	48 (40%)	**120 (100%)**	**0.74**
Total (No. & %)	**148 (48.05%)**	**22 (7.15%)**	**138 (44.80%)**	**308 (100%)**	

Source: Field Survey

As seen from Table 6.17 performance rewards are based on adequate assessment in 56.25% of the corporate hospitals. But in the majority of the mission-run (56.52%) and societies/trusts (50%) hospitals the rewards are based on favouritism. So in corporate hospitals though promotion is based on favouritism, performance rewards are awarded only to deserving candidates.

Performance rewards could be monetary or non-monetary. Almost all the hospitals surveyed had non-monetary awards like appreciation certificates and mementos. Monetary awards were rare, rather confined to nursing colleges, for the best student.

It was found imperative to test whether there exists any significant difference between the employees under different ownerships (corporate, mission-run and trusts/societies) on the issue of awarding performance rewards. For this purpose Analysis of Variance (ANOVA) was done and F-ratio was found out. The details of the analysis done in this regard are given in Table 6.18:

Table 6.18

Summary of ANOVA on Performance Rewards are Based on Objective and not on Favouritism under Different Ownerships

Source	Sum of Squares	df	Mean Square	F Value
Between groups	3.516	2	1.758	1.91
Within groups	281.515	305	0.923	
Total	285.031	307		

Source: Field Survey

Table value of F

F (2, 151) at 0.05 level = 3.06 *F (2, 151) at 0.01 level = 4.75*

Table 6.18 shows that the obtained F-value is not significant at any level. It means that regarding the performance rewards no significant difference in opinion was observed between employees of the three forms of hospital management groups.

6.6 HOSPITAL POLICIES

Rules and procedures are set forth by the management keeping in mind the overall objective of the hospital. These policies need not necessarily be acceptable to the employees. The policies lay down the rules about availing leave, absence of work, timings, shifts, breaks, confirmation etc.

6.6.1 HOSPITAL POLICIES-- PERCEPTION

Policies framed by the management had always been a point of dispute. Every strike has had its origin on some policy framed by management.

The employees were asked whether they found hospital policies favourable to them or not. The responses of the employees are given in Table 6.19:

Table 6.19

Perception of Employees on Hospital Policies

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	70 (72.90%)	6 (6.30%)	20 (20.80%)	**96 (100%)**	**0.46**
Mission-run (No. & %)	52 (56.50%)	6 (6.50%)	34 (37%)	**92 (100%)**	**0.53**
Trusts/Societies (No. & %)	40 (37.30%)	8 (6.70%)	72 (56%)	**120 (100%)**	**0.88**
Total (No. & %)	**162 (52.60%)**	**20 (6.50%)**	**126 (40.90%)**	**308 (100%)**	

Source: Field Survey

Employees belonging to corporate (72.90%) and mission-run (56.50%) hospitals are not satisfied with their hospital policies, while 60% of the employees under hospitals managed by societies/trusts are happy with the policies of the hospitals. This factor could be the major reason for employee displeasure. The responsibility of an HR department would be phenomenal in a situation like this.

6.6.2 HOSPITAL POLICIES – DISMISSAL/SUSPENSION

One of the most sensitive policies of any organisation is the suspension/dismissal policy. But this must be informed to all employees when

they join to make them understand the existing system. When enquired whether prior information of the suspension/dismissal procedures are provided, the employees revealed the following details:

Table 6.20

Information on Suspension/Dismissal of Hospital Employees

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	38 (39.60%)	8 (8.30%)	50 (52.10%)	**96 (100%)**	**0.66**
Mission-run (No. & %)	40 (43.50%)	4 (4.30%)	48 (52.20%)	**92 (100%)**	**0.62**
Trusts/Societies (No. & %)	30 (25%)	8 (6.70%)	82 (68.30%)	**120 (100%)**	**0.94**
Total (No. & %)	**108 (35.06%)**	**20 (6.50%)**	**180 (58.44%)**	**308 (100%)**	

Source: Field Survey

As is evident from Table 6.20, a sizeable proportion of the employees (58.44%) affirmed that they were informed earlier of suspension/dismissal procedures. But the fact remains that 41.56 % employees had no idea about the suspension or dismissal proceedings in their respective hospitals. If these hospitals do not have a formal appraisal system, employees would be in utter shock when they understand about their suspension/dismissal. This leads to dissatisfaction among employees.

It was found imperative to test whether there exists any significant difference in the opinion of the employees under different

ownerships (corporate, mission-run and trust) on the acceptance of hospital policies to them. For this purpose Analysis of Variance (ANOVA) was done and F-ratio was found out. The details of analysis are given in Table 6.21:

Table 6.21

Summary of ANOVA on the Favourability of Hospital Policies to Employees in Hospitals under Different Ownerships

Source	Sum of Squares	df	Mean Square	F Value
Between groups	16.944	2	8.472	10.24**
Within groups	252.235	305	0.827	
Total	269.179	307		

Source: Field Survey

*** significant at 0.01 level*

Table value of F (2, 151) at 0.05 level = 3.06 F (2, 151) at 0.01 level = 4.75

Table 6.21 shows that the obtained F-value is significant at 0.01 level. It means that regarding the acceptance of hospital's policies by employees, employees of hospitals under different ownership are not identical in their views.

If three or more groups are being compared and if the differences between the groups under comparison are found to be significant, it is necessary to do further analysis in order to identify groups which differ significantly. Scheffé Test has the greatest power and leads to the smallest number of significant differences and is also most conservative with respect to

Type 1 error. So, Scheffé test was used in order to identify the groups which differ significantly.

The Scheffé Test is closely linked with ANOVA and requires only the F-Table in performing computations. The basic procedure in the Scheffé method is to compute the limits of a Confidence Interval (CI) for each difference between means. If a difference between means lies within the Confidence Interval (CI) computed for a given level of significance, then, the difference is significant. The details of the analysis are given in Table 6.22:

Table 6.22

Data and Results of Scheffé Test Between

Three Forms of Hospital Management

Groups compared	Mean difference (I-J)	95% Confidence Interval	
		Lower Bound	Upper Bound
Between Corporate and Mission-run	-0.33	-0.79	0.14
Between Corporate and Trust	-0.79*	-1.22	-0.35
Between Mission-run and Trust	-0.46*	-0.90	-2.16 E-02

** significant at 0.05 level*

Table 6.22 shows that there is significant difference between employees of corporate and trust hospitals and between mission-run and trust hospitals with respect to the acceptance of hospital policies to the employees.

No significant difference was noted between employees of corporate and mission-run hospitals on the acceptance of hospital policies to the employees.

6.7 FAIRNESS OF PAY

Fair salary is an important motivating factor for any employee. The basic idea of fair pay is to induce a high level of individual, group or organisational performance. The criteria to decide on this amount could be employee output, hospital's performance, cost savings to the hospital, etc.

6.7.1 FAIRNESS OF PAY-- COMPATIBILITY

To explore the fairness of the pay packet received by the employees and to find out the compatibility of salary with the prevailing rates in the market data was collected and analysed. The results of the analysis done in this regard are given in Table 6.23:

Table 6.23

Compatibility of Salary

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	66 (68.75%)	-	30 (31.25%)	**96 (100%)**	**0.5**
Mission-run (No. & %)	60 (65.20%)	-	32 (34.80%)	**92 (100%)**	**0.5**
Trusts/Societies (No. & %)	80 (66.70%)	-	40 (33.30%)	**120 (100%)**	**0.64**
Total (No. & %)	**206 (66.88%)**	-	**102 (33.11%)**	**308 (100%)**	

Source: Field Survey

It is evident from Table 6.23 that majority of the employees under all the management groups (66.88%) are not satisfied with their present salary. They feel that their present salary is not compatible with the prevailing rates in the market. This factor could be one of the various reasons for the high attrition in the private hospital sector.

6.7.2 FAIRNESS OF PAY--EXPERIENCE

Experience matters in the hospital sector. There is a shortage of experienced personnel, especially nurses, in the hospitals in Kerala due to which retired nurses are appointed on contract basis. So definitely experience should be one criterion to fix the salary of employees.

Following are the details revealed by employees regarding the weightage given to their experience in fixing salary:

Table 6.24

Management Considers Experience in Fixing Salary

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	28 (29.17%)	4 (4.16%)	64 (66.67%)	**96 (100%)**	**0.74**
Mission-run (No. & %)	44 (47.83%)	6 (6.52%)	42 (45.65%)	**92 (100%)**	**0.59**
Trusts/Societies (No. & %)	40 (33.30%)	6 (5%)	74 (61.70%)	**120 (100%)**	**0.88**
Total (No. & %)	148 (48.05%)	16 (5.20%)	144 (46.75%)	**308 (100%)**	

Source: Field Survey

It is seen that generally corporate and hospitals managed by trusts consider experience in fixing salary. In mission-run hospitals (45.65%), though, experience is not always a criterion for fixing an employee's salary. This element brings in discontentment among the employees in private hospitals.

6.7.3 FAIRNESS OF PAY--MOTIVATES

Pay is considered a primary motivator and if it is not negotiated and fixed, brings discontent employees.

Table 6.25

The Salary Structure Motivates Employees in Hospitals

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	53 (55.20%)	8 (8.30%)	35 (36.45%)	**96 (100%)**	**0.56**
Mission-run (No. & %)	58 (63.04%)	4 (4.30%)	30 (32.60%)	**92 (100%)**	**0.5**
Trusts/Societies (No. & %)	52 (43.33%)	8 (6.66%)	60 (50%)	**120 (100%)**	**0.8**
Total (No. & %)	**166 (53.90%)**	**20 (6.50%)**	**122 (39.60%)**	**308 (100%)**	

Source: Field Survey

It can be seen from Table 6.24 that in the case of corporate (55.20%) and mission-run (63.04%) hospitals the prevailing scheme of salary does not motivate the employees. But in the case of trust hospitals 50% of the employees interviewed were motivated by the present scheme. Salary is a very sensitive issue and if the human resource department does not give importance to this aspect there is every reason that the employees will leave the organisation.

6.8 TOP MANAGEMENT

Unless the atmosphere in a hospital is employee-friendly, the employees may turn hostile towards the organisation where they work, which, in turn will result, in employee turnover. The employees must have trust and faith in the management. The person who acts as a liaison between employer and employee would be the hospital administrator or human resource manager.

The perceptions of employees towards their top management in private hospitals of Kerala were investigated.

6.8.1 TOP MANAGEMENT-- PERCEPTION

The employees responded to the question on whether the top management ensures enjoyable work to employees. The details are given in Table 6.26:

Table 6.26

Perception of Employees about Top Management

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	16 (33.30%)	3 (6.30%)	29 (60.40%)	**48 (100%)**	**0.35**
Mission-run (No. & %)	26 (56.50%)	4 (8.70%)	16 (34.80%)	**46 (100%)**	**0.26**
Trusts/Societies (No. & %)	10 (16.70%)	5 (8.30%)	45 (75%)	**60 (100%)**	**0.5**
Total (No. & %)	**52 (33.75%)**	**12 (7.80%)**	**90 (58.45%)**	**154 (100%)**	

Source: Field Survey

In 60.40% of the corporate hospitals and 75% of the hospitals managed by trusts/societies top management ensured enjoyable work to employees. But in 56.50% of the mission-run hospitals they do not follow this practice of creating a favourable working condition to the employees. The management must ensure an enjoyable workplace to employees if they must remain with the hospital.

6.8.2 TOP MANAGEMENT--TRUST

The employees rated the top management's trust, belief and approach towards them. The analysis done in this regard is given in table 6.27:

Table 6.27

Top Management Believes in You and Treats You Humanely

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	8 (8.30%)	10 (10.40%)	79 (81.30%)	**96 (100%)**	**0.86**
Mission-run (No. & %)	18 (19.60%)	6 (6.50%)	68 (73.90%)	**92 (100%)**	**0.75**
Trusts/Societies (No. & %)	18 (15%)	14 (11.70%)	88 (73.30%)	**120 (100%)**	**1.01**
Total (No. & %)	**44 (14.30%)**	**30 (9.75%)**	**234 (75.95%)**	**308 (100%)**	

Source: Field Survey

The employees agreed that majority of the top managements of hospitals under study understood, believed and treated them humanely. Such a positive feeling can bring commitment among the employees, who would like to associate with the hospital for a longer duration.

6.8.3 TOP MANAGEMENT--POTENTIAL

The responses of the employees on the identification and utilisation of the employee potential is given in Table 6.28:

Table 6.28

Top Management Identifies and Utilises the Employee Potential

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	54 (56.25%)	6 (6.25%)	36 (37.50%)	**96 (100%)**	**0.56**
Mission-run (No. & %)	36 (39.10%)	8 (8.70%)	48 (52.20%)	**92 (100%)**	**0.63**
Trusts/Societies (No. & %)	26 (21.67%)	8 (6.67%)	86 (71.66%)	**120 (100%)**	**0.97**
Total (No. & %)	**116 (37.65%)**	**22 (7.15%)**	**170 (55.20%)**	**308 (100%)**	

Source: Field Survey

Table 6.27 reveals that the top management of the mission-run (52.20%) and trust (71.66%) hospitals of Kerala under study identifies and utilises the employees' potentials more, compared to the corporate hospitals (37.50%).

It can be inferred from the preceding discussion that the top management of the private hospitals in Kerala under study pursues an employee-friendly attitude.

6.9 EMPLOYEE TURNOVER

Employee dissatisfaction and aspiration always result in searching for better opportunities. The employees were asked whether they will leave the present organisation if an alternative job of a similar nature was offered to them. Their responses are given below:

Table 6.29

Leaving the Present Organisation for a Similar Job

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	22 (22.90%)	8 (8.30%)	66 (68.80%)	**96 (100%)**	**0.7**
Mission-run (No. & %)	34 (37%)	4 (4.30%)	54 (58.70%)	**92 (100%)**	**0.66**
Trusts/Societies (No. & %)	38 (31.67%)	8 (6.67%)	74 (61.66%)	**120 (100%)**	**0.89**
Total (No. & %)	**94 (30.52%)**	**20 (6.50%)**	**194 (62.98%)**	**308 (100%)**	

Source: Field Survey

It can be seen from Table 6.29 that majority of the employees of all the three different forms of hospital managements would leave the present hospital for an alternative job of a similar nature, though 37% employees of mission-run hospitals disagreed to the same. This table gives a true representation of discontentment among hospital staff.

6.10 WELFARE MEASURES

Welfare measures could be statutory or non-statutory. They aim at providing service facilities and amenities to employees to relieve them of their personal and family worries to improve their health and to afford them a sense of self-expression which enable them in a wider perception of life.

Hospitals comply with statutory welfare schemes for permanent employees. Employees expect various non-statutory welfare schemes from their hospital. The details of the analysis done in this regard are given in Table 6.30:

Table 6.30

Hospital Ensures Various Non-Statutory Welfare Facilities

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	20 (20.80%)	6 (6.30%)	70 (72.90%)	**96 (100%)**	**0.78**
Mission-run (No. & %)	48 (52.20%)	6 (6.50%)	38 (41.30%)	**92 (100%)**	**0.56**
Trusts/Societies (No. & %)	40 (33.33%)	10 (8.33%)	70 (58.34%)	**120 (100%)**	**0.87**
Total (No. & %)	**108 (35.05%)**	**22 (7.15%)**	**178 (57.80%)**	**308 (100%)**	

Source: Field Survey

The various welfare measures adopted by management for employees are satisfactory in majority of the corporate (72.90%) and trust (58.34%)

hospitals. But 52.20% of the mission-run hospitals do not ensure sufficient welfare facilities for the employees. Common non-statutory welfare measures in hospitals include free hostel facilities, conveyance facilities, medical facilities, uniform allowance, subsidised canteen facilities, washing allowance etc.

6.11 RETIREMENT BENEFITS

There are statutory retirement benefits like provident fund, gratuity and contributions to Employees State Insurance that every hospital needs to comply with. The Government of India has made pension mandatory along with provident fund. Permanent employees are assured of these benefits but employees' expectation of ex-gratia pay, contract employment, etc exists.

The satisfaction level of employees on retirement policies was elicited and the details are given in Table 6.31:

Table 6.31

Retirement Benefits

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	46 (47.90%)	6 (6.30%)	44 (45.80%)	**96 (100%)**	**0.61**
Mission-run (No. & %)	58 (63.05%)	4 (4.34%)	30 (32.61%)	**92 (100%)**	**0.5**
Trusts/Societies (No. & %)	84 (70%)	8 (6.70%)	28 (23.30%)	**120 (100%)**	**0.59**
Total (No. & %)	**188 (61.04%)**	**18 (5.84%)**	**102 (33.12%)**	**308 (100%)**	

Source: Field Survey

It is evident from Table 6.30 that majority of the employees belonging to the mission-run (63.05%) and trust hospitals (70%) are not satisfied with the retirement benefits offered to them, while 45.80% employees of the corporate hospitals are happy with the retirement benefits offered by the management. It is quite common to have provident fund and gratuity in hospitals, but over and above this there are only very few. The time taken by the hospitals for providing clearance to the different offices of gratuity, ESI etc were also cited as reasons for dissatisfaction.

6.12 LEGISLATIVE ENACTMENTS

There are various enactments that hospitals need to follow like Payment of Wages Act, Provident Fund Act etc. The employees' awareness level of these Acts was enquired.

Table 6.32

Hospital Employees' Awareness of Legal Aspects

Nature of Ownership	Responses			Total	Weighted Average Score
	No	Neutral	Yes		
Corporate (No. & %)	48 (50%)	6 (6.25%)	42 (43.75%)	**96 (100%)**	**0.6**
Mission-run (No. & %)	60 (65.20%)	6 (6.50%)	26 (28.30%)	**92 (100%)**	**0.48**
Trusts/Societies (No. & %)	52 (43.30%)	8 (6.70%)	60 (50%)	**120 (100%)**	**0.8**
Total (No. & %)	**160 (51.95%)**	**20 (6.50%)**	**128 (41.55%)**	**308 (100%)**	

Source: Field Survey

It is seen from Table 6.32 that majority of the employees working in corporate (50%) and mission-run (65.20%) hospitals are not aware of the various legislations including the Minimum Wages Act. Only 50% of the staff of trust hospitals was aware of the Act. This ignorance is being capitalised by the hospital management more for the levels of nurses and below. Acts like Minimum Wages Act, Payment of Wages Act, and Provident Fund Act etc should be included in the syllabus of medicine and nursing courses.

Data pertaining to the earlier discussions were used for further statistical analysis to verify the significance of the study and to understand the factors that influenced the different hospitals under different management.

In order to test whether all the selected factors of human resource management (15 variables) are good sets of independent variables weighted average mean score was calculated.

Table 6.33

Weighted Average Score of

HRM Variables in Different Types of Private Hospitals

Variables	Corporate	|Mission-run	Trust
Job Rotation	0.61	0.53	0.65
Psychological Climate	0.72	0.55	0.69
Team Work	**0.84**	**0.68**	**1.11**
Daily Case Discussions	**0.81**	0.62	0.96
Training Seriously	0.72	**0.66**	0.91
Feedback Supervisor	**0.88**	0.63	**1.09**
Performance Feedback Seriously	**0.84**	**0.78**	**1.09**
Mentoring	0.38	0.57	**1.07**
Promotion Suitability	0.54	**0.70**	0.89
Dismissal Procedure	0.66	0.62	0.94
Top Management-Enjoyable Work	0.35	0.26	0.50
Top Management-Humanely	**0.86**	**0.75**	**1.01**
Top Management-Employee Potential	0.56	0.63	0.97
Alternative Employment	0.70	0.66	0.89
Welfare Facilities	0.78	0.56	0.87

Table 6.33 shows the weighted average score of variables influencing human resource management in different types of hospitals. Higher the score of each variable, greater is its relevance to study. Such variables affect the perception of employees on human resource management more compared with other variables with lesser score.

Table 6.34

The Top Five HRM Variables in different types of Hospitals

Type	Variable
Corporate	1. Team Work 2. Daily Case Discussions 3. Feedback Supervisor 4. Perf. Feedback Seriously 5. Top Management-Humanely
Mission-Run	1. Team Work 2. Training Seriously 3. Perf. Feedback Seriously 4. Promotion Suitability 5. Top Management-Humanely
Trust Hospitals	1. Team Work 2. Feedback Supervisor 3. Perf. Feedback Seriously 4. Mentoring 5. Top Management-Humanely

Table 6.35 shows the top five human resource variables that affect the perception of employees in different types of hospitals. Team Work(0.84), Daily Case Discussions(0.81), Feedback from Supervisor(0.88), Performance Feedback(0.84), and Top Management-Humanely(0.86) have high mean score of 0.80 and above, proving that these factors positively

influence the perception of human resource management among employees working in corporate hospitals.

Team Work(0.68), Training Seriously(0.66), Performance Feedback(0.78), Promotion(0.70) and Top Management-Humanely(0.75), influence the perception of human resource management among employees working in mission-run hospitals, since these factors have high weighted average mean score.

Factors like Team Work(1.11), Feedback from Supervisor(1.09), Performance Feedback(I.09), Mentoring(1.07) and Top Management-Humanely(1.01) influence the perception of human resource management among employees working in hospitals managed by trusts/societies, since these factors have high weighted average mean score.

6.13 CONCLUSION

Even though there are certain similarities in factors like Team Work, Performance Feedback and Attitude of Top Management, it could be concluded that different factors influence the perception of employees about human resource management in different types of hospitals. Among the 15 factors considered for further analysis, five variables each, with high score, revealed that employees perceive these factors to contribute to better human resource management practices. In order to ensure a highly motivated and committed group of employees the management of hospitals must necessarily consider the remaining ten factors while devising HR policies.

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Chapter VII

SUMMARY AND CONCLUSIONS

CONTENTS

CHAPTER VII

SUMMARY AND CONCLUSIONS

The healthcare sector in Kerala is witnessing a spiralling growth due to the healthy economic development and the serious outlook of individuals towards personal health. Private sector is thriving exuberantly well since there is a wide gap between demand and supply for healthcare due to the lack of government initiatives. The proliferation of these private hospitals have paved the way for many unhealthy practices like poor working conditions, low wages, excess workload and lack of retirement and welfare measures to the employees. This state of affairs demanded a serious investigation into the functioning of the private hospitals in Kerala, especially on the human resource management practices, as the success of every organisation depends on the satisfaction level of its employees, which, in turn, will benefit the consumer, i.e., the patients.

Hence the present study was undertaken to find out the extent of human resource management practices in private hospitals in Kerala with a view to suggest appropriate remedial measures wherever required. For this purpose an interview schedule was administered to the management of 46 selected private hospitals (corporate, mission-run and societies/trusts) selected for the study to assess the level of human resource management practices exercised by them. In order to assess the extent of human resource climate existing in these hospitals, a questionnaire was also administered to 308 employees. The data collected by these tools were analysed

using appropriate statistical techniques like percentages, correlation, ANOVA, and weighted average score.

In addition to this, secondary sources were also made use of to arrive at suitable conclusions for the study. Reports and publications of Indian Society of Hospital Administrators (ISHA), World Health Organisation (WHO), Administrative Staff College of India (ASCI), Centre for Development Studies (CDS) Thiruvananthapuram, C Achutha Menon Memorial Library, Thiruvananthapuram, Kerala State Planning Board, Thiruvananthapuram, Directorate of Health, Thiruvananthapuram etc. were referred for the study.

7.1 OBJECTIVES OF THE STUDY

The overall objective of the study is to assess the effectiveness of human resource management practices in different types of private hospitals in Kerala State. The specific objectives of the study are:

1. To investigate into the different Human Resource Management practices in private hospitals, particularly focusing on the problems, limitations and effectiveness of these practices.
2. To identify the reasons for the high rate of employee turnover in the private hospitals in Kerala.
3. To examine whether factors influencing human resource management differ with hospitals under different managements.
4. To examine how the working environment can be improved and a favourable work culture introduced in the private hospitals.

5. To draw some conclusions and make recommendations for the effective human resource management practices in the private hospitals in Kerala.

7.2 CHAPTER SCHEME

Chapter 1 gives a brief introduction alongwith the statement of the problem, significance of the study, objectives to be examined, methodology adopted, sources of data, limitations and scheme of chapterisation.

Chapter 2 deals with literature survey pertaining to the topic of the study in the Indian and global scenario.

Chapter 3 explains in detail about hospitals – their origin, health status of Kerala, public health spending by the state governments in India, budget and health and Government healthcare infrastructure. The Private Hospital Sector, Reasons for Slow Growth of Hospitals etc are also explained in this chapter.

Chapter 4 is devoted to explain the various functional areas of managing hospitals. Starting with types of hospitals, the chapter has covered organizational structure with Henry Mintzberg model. Other areas include medical departments like surgery, nursing, general medicine, pharmacy, pathology etc and functional management departments like finance, marketing, human resource, materials and stores etc. Significance of human resource management and human resource climate is explained in detail in this chapter.

Chapter 5 provides an analysis of the interview schedule given to the hospital administrators/directors. The interview schedule covers areas namely, general details about the hospitals under study, decision-making practices, various HR issues like

manpower planning, recruitment and selection, training, promotion, transfer, performance appraisal, compensation, communication networks and industrial relations.

Chapter 6 deals with the analysis of the questionnaire given to employees (doctors, nurses and para-medical staff), to assess their perception about a good human resource management system in their respective hospitals. This questionnaire has 12 sections which include Working Environment, Cooperation, Training Programme, Performance Feedback, Favouritism, Policies, Fairness of Pay, Top Management, Employee Separation, Welfare Measures, Retirement Benefits and Legislative Enactments. Data received from 308 employees were used for analysis.

Chapter 7 is meant for giving a summary and suggesting conclusions of the study. It also highlights the areas where management and employee's opinion on human resource management practices differ or agree. Both parties converge in areas like training, communication and certain aspects of performance management. Differences of opinion exist in areas like fairness of pay, welfare, employee separation, etc.

7.3 MAJOR FINDINGS OF THE STUDY

The important findings of this research work are summarised in this section to understand the areas of convergence of ideas by employers and employees on human resource management. The management has their views on various aspects and they need not necessarily be favourable to the employees of the hospital. The first part presents the findings that emerged out of the analysis of data collected from hospital

managements and the second part deals with the perceptions of employees on the human resource management practices prevailing in their hospitals. The details are given below:

7.3.1 Findings based on Human Resource Management Practices in Private Hospitals in Kerala

Data collected from managements of 46 allopathic hospitals from eight districts of Kerala were analysed and interpreted. Findings of the study include the following:

7.3.1.1 Human Resource Department

All corporate hospitals have a human resource department. This practice is less prevalent in hospitals run by societies and trusts. In 46% of mission-run hospitals and 71% of hospitals managed by societies and trusts, all activities of an HR department are carried on by the hospital administrator.

7.3.1.2 Decision-Making Practices

Centralised decision-making is a phenomenon in all the hospitals under corporate management (100%). Majority of the hospitals managed by societies and trusts (71%) and 67% of the mission-run hospitals also follow centralised decision-making.

7.3.1.3 Recruitment Practices

Sixty per cent of the hospitals under corporate managements consider hospital expansion as the criterion for recruitment. Mission-run hospitals recruit employees to meet the excess workload (66.66%) and for hospitals managed by societies and trusts

the basis for recruitment is hospital expansion (64.52%), quiet similar to corporate hospitals.

7.3.1.4 Criteria for Selection: Qualifications and Experience

(i) Majority of the hospitals make the selection of their clinical and non-clinical staff on the basis of both education and experience. Almost 60 per cent of the hospitals always counted on experience in the process of selection of candidates. One unique feature to be noticed here is that corporate hospitals do not entertain reference as a criterion for employee selection, while in hospitals managed by societies and trusts there is a substantial role for reference of candidate.

(ii) None of the hospitals (89.13%) studied considered marks as the only criterion for the selection of doctors. Marks coupled with experience or reference mattered most. Corporate hospitals did not consider any community as a criterion for the selection of doctors. Only the mission-run hospitals consider 'community' along with other factors like marks and experience.

(iii) Selection of nurses in 100 per cent of the private hospitals studied give priority to marks, experience and reference of the candidate. Eighty per cent of the mission-run hospitals consider experience and community as a major factor for selecting nurses. Hospitals managed by societies and trusts also considered community, provided they possessed marks and experience also.

(iv) Marks, experience and reference are considered as the major criteria for the selection of para- medical staff in hospitals studied under different managements.

7.3.1.5 Mode of Communication

(i) Majority of the corporate hospitals issue appointment letters to their staff at the time of their joining itself though it is not similar in the other two types of private hospitals. In corporate hospitals appointment letters are provided to all the permanent employees, irrespective of job category. In the mission-run and the hospitals managed by societies and trusts, permanent employees of the categories of junior nurses and below are provided the joining letters only on request.

(ii) Appointment letters issued by majority of the corporate hospitals contain salary details (80%) and job description (100%). Salary payable is not always specified in all the appointment letters in the hospitals studied.

(iii) Memos/circulars are used by 48% of hospitals and 36 % hospitals depend on individual letters for communicating with employees. Wherever matters had to be conveyed individually, the management used letters and issues on common human resource management were conveyed through circulars.

(iv) According to the management representatives, majority of employees (50%) use exit interview as the medium to communicate their grievances to the management. Suggestion box is considered by only 17.4 per cent of the respondents. Grievance procedure is also an accepted channel of communication used by employees through the grievance cell existing in hospitals.

7.3.1.6 Awareness of Personnel Policies

Personnel policies are not made known to all the employees by majority of the hospitals (52.38%) studied. Still, a good number of the hospitals managed by societies and trusts (47.61%) inform the employees their hospital's human resource policies.

7.3.1.7 Capacity Building Process

(i) Orientation programmes for the new recruits are conducted by majority of the hospitals under the three management groups studied. The department heads in case of doctors and nursing superintendents in case of nurses and auxiliary staff do these orientation programmes.

(ii) Majority of the hospitals under study (71.74%) have their own training policies.

(iii) From among the 46 hospitals studied, only 18 are interested in sending doctors for training and 22 for sending nurses. It is noteworthy that 93 per cent of the hospitals did not have any policy of sending their para-medical staff for any kind of training.

(iv) Post-training appraisal is conducted only by 30% of the hospitals studied for their employees after they return from training.

(v) Majority of the mission-run hospitals (73.33%) and 50 per cent of the corporate hospitals always permit their trained staff to administer new skills acquired through training. Hospitals managed by trusts (42.86%) are also in favour of permitting their employees in implementing skills learnt by them through training received from external agencies.

(vi) Para-medical staff is rarely sent for seminars or conferences by majority of the hospitals managed by societies/ trusts and mission. On the contrary, corporate hospitals as a policy send majority of their employees for training.

7.3.1.8 Performance Appraisal System

(i) It is seen that all the corporate hospitals (100%) have a performance appraisal system in place and a majority of the mission-run (60%) and societies/trusts (61.91%) hospitals also have a performance appraisal system.

(ii) Wage/salary revision was ranked as the first use of performance appraisal by 32.60 per cent of the hospitals and 23.91 per cent used performance appraisal for training needs identification. Verbal feedback is ranked first by 17.39 per cent of the respondents. Only six hospitals each gave promotion and transfer as the first use of performance appraisal. Verbal feedback is ranked by 29.26 per cent of the hospitals as the second use of performance appraisal.

(iii) Quantity of work done was ranked as the prime criterion for 6.52 per cent of the respondents, while 54.35 per cent consider regularity at work as the prime criterion for performance appraisal. Thus a person who takes less leave and is regular at work is ranked highest. Quality of work is ranked first by 50 per cent of the respondents as the criterion for performance appraisal.

7.3.1.9 Employee Turnover

(i) The primary reason for labour turnover according to majority of the hospitals is better job prospects abroad. In the case of mission-run hospitals better job prospects within India also lured employees from their present organisation. But

marriage as 'always' a prime reason for leaving the present organisation was cited only by hospitals run by trusts and societies (52.38%).

(ii) No significant difference was found among the private hospitals under the three managements in the case of the reasons like better job prospects abroad and better job prospects in India when tested for significance using ANOVA. But in the case of marriage as 'always' the reason for labour turnover, significant difference was observed ($F = 6.32$; $p < 0.01$) for hospitals under different managements. As seen earlier, the hospitals run by societies and trusts experience more employee turnover due to marriage.

7.3.1.10 Salary Administration

Corporate hospitals consider cost of living, productivity, prevailing rates in the industry and retention practice, while fixing salaries for doctors, nurses and para-medical staff. Mission–run hospitals and hospitals managed by societies/ trusts consider collective bargaining strength alongwith other factors since trade union exists in some of these hospitals, though trade unions are consulted only for lower level employees and not for doctors, nurses or para-medical staff.

7.3.1.11 Welfare Schemes

(i) Majority of the corporate hospitals offer financial incentives for motivating their employees. Doctors are paid private practice allowance and senior doctors have case allowance, i.e. for every special case they attend to, they receive a special pay. Some hospitals also have a system of paying a retainer fee to doctors.

For permanent nurses and other para-medical staff, financial motivators like interest-free housing loans, washing allowances, subsidised canteen facilities, free hostel facilities for unmarried staff and travel allowance exist.

In majority of the hospitals managed by trusts and societies there is no system of providing any financial incentive other than the statutory benefits that the hospitals have to necessarily comply with under Industrial Disputes Act, Employees State Insurance Act and the Labour Welfare Board.

(ii) Awards and certificates are distributed for motivating their employees by the majority of hospitals (56.09%), but it is sad to note that there are hospitals that do not have any non-financial motivators as well.

(iii) The obtained F-values are not significant at any level. It clearly shows that there is no significant difference among the different hospitals classified on the basis of management (Corporate, Mission-run and Trusts) on the welfare measures such as financial motivators and non- financial motivators. It suggests that irrespective of the type of management of hospitals the welfare measures for employees adopted by hospitals are not significantly different.

7.3.1.12 Retirement Policies

(i) Hospitals are complying with all the statutory benefits for permanent staff like Provident Fund, Gratuity, Employees State Insurance and contributions to State Labour Welfare Board.

(ii) Corporate hospitals, mission-run and hospitals managed by societies/trusts had in general a policy of appointing doctors, nurses and para-medical staff. Subsidised medical treatment is provided for all the three categories of

employees by majority of the hospitals though non-statutory welfare schemes are almost absent for all.

7.3.1.13 Employee Grievance

Reasons for grievances for doctors were poor facilities provided to them – both clinical and personal – followed by disciplinary actions. Promotion was another cause of concern for doctors.

In the case of nurses, salary increment policies mattered most followed by salary as cause of grievance. The next reason for employee grievance was on facilities – clinical and personal – provided. They also lacked a proper course for individual advancement.

Regarding para-medical staff, majority of the respondents view their chances of promotion as almost nil. They also rated increment and salaries to be very low.

7.3.1.14 Trade Unions

In the majority of the hospitals under the corporate sector (80%) there is no role for trade unions in determining the wages. But in 33.3% of the mission-run hospitals the trade unions have a role in determining the wages of employees, more specifically for nurses, para-medical staff and other lower level employees.

7.3.2 Findings based on Employees' Perception on Human Resource Management Practices in Private Hospitals in Kerala

The sample comprised of 96 (31.17%) employees who are working in the corporate hospitals, 92 (29.87%) in the mission hospitals and 120 (38.96%) in the hospitals owned by trusts and societies.

7.3.2.1 Working Environment

(i) Forty-two per cent of the employees in the corporate hospitals, 37% in the mission-run hospitals and 30% in the hospitals managed by societies and trusts are unhappy with the present job rotation policies.

(ii) Majority of the staff under the corporate and trust-managed hospitals experience a psychological climate which is conducive for working (62.50% and 70% respectively). But 54.30% of the employees of the mission-run hospitals did not experience a similar work environment.

(iii) There is a mixed response of the modes of communication used by employees of private hospitals studied. When 63% employees of the corporate hospitals communicated their problems directly to their heads of departments, 54% of the mission-run hospitals and 70% of the employees of the hospitals managed by trusts and societies depended upon suggestion box.

(iv) ANOVA suggests that the factor 'working environment' is significant since the level of significance is less than 0.5. Thus we can accept the fact that the various factors under 'work environment' influence the perception of the human resource management practices in private hospitals studied in Kerala.

7.3.2.2 Co-operation

(i) Team work is highly encouraged in 79 per cent of the hospitals under the three different types of managements.

(ii) Medical cases are discussed openly between different levels of staff with the objective of solving them in 77% of corporate, 50% of mission-run and 72% of society/trust-managed hospitals.

(iii) Hospitals managed by trusts (85%) have a systematic mentoring policy than any other type of hospital. Majority of the corporate hospitals (85.40%) and mission-run hospitals (52.20%) do not give attention to this aspect due to their hectic schedule.

(iv) The mean value for ANOVA test on cooperation is less than F value. It means that the mean value is significant i.e. there is cooperation among employees of private hospitals under different forms of managements.

7.3.2.3 Training Programmes

(i) Majority of the employees from the three forms of management (79.22%) takes sponsored training by the hospitals seriously and tries to learn from the programmes they attend.

(ii) Opportunities to try out what they have learnt from training programmes are provided by majority of the employees (62.34%).

7.3.2.4 Performance Feedback

(i) Employees obtain feedback about their strengths and weaknesses from supervising staff from 87.50% of the corporate hospitals and 83.34% of the society/trust managements, while only 52.20% of the employees from the mission-run hospitals receive the feedback about their performance.

(ii) All the employees under corporate, mission-run and trust-managed hospitals take the performance feedback seriously and utilise it for their development.

(iii) Employees of 52.10% of the corporate and 63.30% of trust hospitals agreed that good work is appreciated in their hospitals, though the rate of appreciation is not up to the expectation that 'good work pays'.

(iv) Comparison of the three groups from the different management showed no significant difference in the utilisation of performance feedback ($F = 0.832$; $p > 0.05$). That is, irrespective of the management, employees under the three managements utilise the performance feedback for their development.

7.3.2.5 Favouritism

(i) In 58.30% of the corporate hospitals promotion is based on favouritism, whereas in the case of 65.20% mission-run and 63.30% of the trust-managed hospitals promotion is based on the efficiency of the person. Efficiency is given due acknowledgement in the mission-run and trust hospitals.

(iii) Performance rewards are based on adequate assessment in 56.25% of the corporate hospitals. But in the majority of the mission-run (56.52%) and trust (50%) hospitals the rewards are based on favouritism.

7.3.2.6 Policies

(i) Employees belonging to corporate (72.90%) and mission-run (56.50%) hospitals are not satisfied with the hospital policies on employees, while 60 per cent of the employees under society/trust managed hospitals showed satisfaction with the policies of the hospitals.

(ii) Suspension/dismissal procedures were informed earlier in majority of the hospitals (58.44%), though 41.56% are fully unaware of them.

(iii) Comparison of the opinion of employees under the three different management showed significant difference in their views on hospital policies ($F = 10.24$; $p < 0.01$). Scheffé test of post hoc comparison revealed

significant difference between employees of corporate and trust hospitals and between mission-run and trust hospitals with respect to acceptability of hospital policies to employees. No significant difference was noted between employees of corporate and mission-run hospitals on the acceptance of hospital policies to employees.

7.3.2.7 Fairness of Pay

(i) Majority of the employees under all the management groups (66.88%) are not satisfied with their present salary. They feel that their present salary is not compatible with the prevailing rates in the industry.

(ii) Corporate hospitals and trust hospitals consider experience while fixing salary (66.67% and 61.70% respectively) for employees. In the case of mission-run hospitals (45.65%) experience is not always a criterion for fixing an employee's salary.

(iii) The prevailing salary scheme of corporate (55.20%) and mission-run (63.04%) hospitals does not motivate the employees. Employees of trust hospitals(50%) interviewed agreed that they were motivated by the present salary scheme.

7.3.2.8 Top Management

(i) In 60.40% of the corporate and 75% hospitals managed by the societies/trusts enjoyable work is ensured to employees, though 56.50 per cent of the mission-run hospitals do not follow this practice.

(ii) The top management of the majority of the hospitals under the three managements (75.95%) believes in their employees and treats them humanely.

(iii) Top management of the mission-run (52.20%) and society/trust (71.66%) hospitals of Kerala under study identifies and utilises the employees' potentials more compared to the corporate hospitals (37.50%).

7.3.2.9 Employee Turnover

Employees from all the three different management groups would leave the present hospital for an alternative job of a similar nature, though 37% employees of mission-run hospitals disagreed to the same.

7.3.2.10 Welfare Measures

The various welfare measures adopted by the management for the employees are satisfactory in the majority of the corporate (72.90%) and society/trust (58.34%) hospitals. But in 52.20% of the mission-run hospitals the hospitals do not ensure various welfare facilities for the employees.

7.3.2.11 Retirement Benefits

Majority of the employees belonging to the mission-run (63.05%) and trust hospitals (70%) are not satisfied with the retirement benefits offered to them, while 45.80% of the employees of the corporate hospitals are happy with the retirement benefits offered by their management.

7.3.2.12 Legislative Enactments

Exactly 50 per cent of the employees working in the corporate hospitals and 65.20 per cent of the mission-run hospitals are not aware of the various labour

legislations. But in a good number of trust hospitals (50%) employees are aware of the Minimum Wages Act.

7.3.2.13 Overall Findings

Different human resource variables affect the perception of employees in different types of hospitals. When Team Work, Daily Case Discussions, Feedback from Supervisor, Performance Feedback and Humanely approach of Top Management influenced the perception of human resource management among employees working in corporate hospitals, Team Work, Serious Training, Performance Feedback, Promotion and Humanely approach of Top Management influenced the perception of human resource management among employees working in mission-run hospitals. Team Work, Feedback from Supervisor, Performance Feedback, Mentoring and Humanely approach of Top Management influenced the perception of human resource management among employees working in hospitals managed by trusts/societies also. As such there are similarities in variables that influenced the perception of human resource management of private hospitals positively.

7.4 RECOMMENDATIONS

Based on the above findings of the study the following recommendations are made, which will pave the way for a healthy human resource management practice in the private healthcare sector in Kerala.

7.4.1 Human Resource Department

Every hospital must set up a human resource department headed by a qualified human resource manager. Functions of a hospital administrator should be separated from the human resource manager. All functional aspects of human resources which are plenty in hospitals, since it is employee-dependent should be carried on by the human resource manager. A good human resource manager can help build good employer-employee relationship.

7.4.2 Centralised Decision-making

Though majority of the hospitals studied are practising centralised decision-making, it is not prevalent in all the hospitals. Centralised decision-making for human resource must be established in all the private hospitals. This can provide the management a clear picture of the employee-related activities like number of appointments, dismissals, reasons for leaving jobs, promotion, training etc, and these information can assist them in rethinking various human resource policies already implemented, or going to be implemented.

7.4.3 Recruitment

It was found that criteria for recruitment are not manpower plan or hospital expansion in majority of the hospitals. Manpower plan-based recruitment is the ideal recruitment procedure. The human resource department should be able to plan the

manpower requirements for a year. Employees will feel work pressure if hospitals follow an unscientific method of recruiting as and when adequate staff is not available, which, in turn, will affect the quality of functioning at the hospital.

7.4.4 Personnel Policies

The study showed that majority of the hospitals does not reveal the personnel policies to the employees in writing. Unless there is transparency from the part of the employer on personnel policies the trust of the employees towards the organisation they work will get diluted. This anomaly must be addressed properly by providing timely information to the employees on the personnel policies of the hospital, so as to make them convinced about their importance in the organisation.

The employees were also not satisfactory with the hospital policies of management. The various welfare measures adopted by the management were also found to be not satisfactory in the majority of the hospitals. Hospital management should ensure that an employee-centric policy must be adhered to in winning the trust of the employees, which could ultimately benefit the hospital.

7.4.5 Training received by Doctors and Nurses

A good number of the hospitals under study does not seem to have a proper training policy for their staff, especially doctors and nurses. As the medical profession is changing rapidly due to intense research and newer technologies training and post-training appraisal to medical and para-medical staff must be made compulsory in private hospitals. Employees should also be allowed to administer new skills acquired through training to encourage them to get hands-on-experience. It will enhance the morale and acceptance of the management among employees.

7.4.6 Seminars and Conferences

Hospital managements are hesitant to send their employees, more specifically, nurses and para-medical staff for seminars and conferences. In a rapidly changing field like medical science, up-to-date knowledge of the happenings is of utmost importance for any employee. So, participation of employees in seminars and conferences must be encouraged by the management.

7.4.7 Individual Advancement

Promotion for doctors and nurses was found to be limited in corporate and trust hospitals compared to mission-run hospitals. Adequate promotion must be provided to all the employees in the hospitals, especially to doctors and nurses. In addition to that, employees felt that promotion was based on favouritism rather than the suitability of the person, especially in corporate hospitals. This system of promotion should be checked urgently as this will erode the trust of employees in hospitals.

7.4.8 Mentoring

Though mentoring was common in society/trust-managed hospitals it was almost absent in hospitals under corporate and mission-run management. Hospitals must change their strategy and assist in helping employees who lack skills. It was also found that in majority of the corporate hospitals the guidance to juniors by seniors for future job responsibilities is absent. Nonavailability of time is the reason cited by employees. If the hospitals can systematically allocate work and develop a system where seniors are allotted a particular time for mentoring, then, skill can be

developed and expertise made use of by hospitals. Such a mentoring system can create a sense of commitment among employees in private hospitals.

7.4.9 Top Management

In a majority of the mission-run hospitals the top management does not ensure a congenial working atmosphere to the employees. Unless the top management is involved in creating an employee-friendly atmosphere in the working sphere, the employees will feel insecure, resulting in quality deterioration and discontentment. The top management of the private hospitals should be actively involved in creating a pleasant working atmosphere to the employees in their hospitals. It was also seen that majority of the top management of the mission-run hospitals is not much aware of the importance of employee development. In addition to the involvement in creating an employee-friendly atmosphere the top management should ensure professionalism. Identification and utilisation of employee potential by top management is of vital importance for any successful organisation. It should always be remembered that employees are the 'internal customers' in any organisation. Unless the internal customers are satisfied, it would be very difficult to get positive feedback from the actual customers, which could create negative consequences to the organisation.

7.4.10 Performance Feedback

Use of performance feedback as a scientific tool to enhance the productivity of employees was found to be good since employees consider this review of performance seriously and utilise it for their development.

7.4.11 Pay Scale Revision

In considering the pay scale revision, only very few hospitals were found to be relying on cost of living, productivity and prevailing wage rate. Nowadays the cost of living is becoming very high in Kerala, and so the pay revision must be essentially linked to the cost of living and productivity of the employee. It is also to be noted that majority of the employees were not satisfied with the present salary structure. One should consider experience and competence of the employee in fixing pay scale. Pay scale should be compatible with other industries and should be the prime motivating factor for an employee. Always pay the promised salary to the employees to avoid deep discontentment among them.

7.4.12 Financial Schemes

A great majority of the hospitals does not have any financial scheme for motivating the employees. Performance-based financial schemes must be implemented in the private hospitals of Kerala.

7.4.13 Non-financial Motivators

Money alone is not a motivating factor in work. Though some hospitals were found to employ awards and certificates for their employees, it is not a common practice in the private hospitals of Kerala. Here also, the practice prevailing in other sectors like best volunteer award, best team worker award, etc., which is best suited to the healthcare sector, would prove to be inspiring to the employees.

7.4.14 Employee Grievances

A good number of doctors and nurses were found to have grievance over poor facilities in the hospitals. Lack of promotion was found to be another unpleasant

reason for doctors. Facilities in the hospitals must be enhanced both for the well-being of the public and for the staff working there. Except for doctors, the major grievance of all other staff is about salary. This should be urgently remedied in such a way as to enable them attain a decent living.

7.4.15 Labour Turnover

Labour turnover was found to be high in private hospital sector which occurs mainly due to opportunities to go abroad. But the study also revealed that a good proportion of the employees is willing to go for better jobs even within India. This phenomenon shows the lack of a stimulating atmosphere in the private hospitals studied. Steps could be taken to reduce the employee turnover by increasing facilities at the hospital, salary and various welfare measures. The study found that majority of the employees of all the three different management groups would leave the present hospital for an alternative job of a similar nature. This clearly shows the employee discontentment and aspiration. This phenomenon shows the lack of welfare measures and inadequacy of salary paid to the employees. For the retention of the employees the management should take urgent steps to reward the employees, which could enable them to earn a decent living. These measures could bring down employee turnover to a great extent, and boost the morale of the employees which could result in increased performance.

It was also pointed out by a good number of the employees of the mission-run and trust hospitals that performance rewards are not based on adequate assessment, but are decided on favouritism of the management. This also could pave way for employee dissatisfaction, thereby causing attrition of the employees. So, like in any

professional organisation, performance rewards in private hospitals also must be decided on adequate assessment of the employee's competence, and not on favouritism.

The above recommendations, if implemented properly, will go a long way in the effective human resource management practices in the private hospitals of Kerala. These steps could create a more efficient and satisfied workforce, which could metamorphose the present-day working of these institutions, which, in turn, will benefit the end-user, the management and the employees of the private hospitals in Kerala in a healthy and constructive manner.

7.5 SUGGESTIONS FOR FUTURE STUDY

In the course of the present study, several avenues for further research in the area under investigation have been identified and a few of which are listed below:

1. A comparative study of the Human Resource Management practices of the government and private hospitals could be attempted.
2. A detailed study of the HRM issues in the private hospitals in other states of India could be done to get an overall view of the practices prevailing all over the country.
3. A study can be attempted into the HR practices of super-speciality corporate hospitals in India (Apollo hospitals, Escorts hospitals etc.) which would be very helpful in evolving a professional human resource management practice for the entire industry.

4. Relationship between quality of service rendered and employee satisfaction in private hospitals is also an interesting area worth studying.

7.6 CONCLUSION

The overall HR management practices in private hospitals in Kerala are fairly satisfactory. There are several areas which need immediate attention of policy makers and the private hospital managements. Policies which will address issues relating to employee discontentment and introduction of a more professional approach to HR management practices is the need of the hour. The study revealed that the existing HR practices are not conducive for delivering quality healthcare to the stake holders. A more professional approach for HR practices will definitely pave the way for containing the high employee turnover and contribute to building a team of highly motivated and committed group of employees. The recommendations of this study, if implemented, will bring about a positive change in the attitude of both the management and employees leading to a healthy work culture in the private hospitals in Kerala. Let all concerned remember; "Health is Wealth....!!!".

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APPENDICES

APPENDIX – I
QUESTIONNAIRE

Employees' Perception Survey of Human Resource Practices in Private Hospitals

I assure you that any information provided in this questionnaire will be kept highly confidential.

Please write YES / NO after each question as your answer.

A. THE WORK ENVIRONMENT

1. There is a policy of rotating jobs in the organization.
   1.Disagree 2.Neutral 3. Agree

2. Psychological climate in hospital is conducive for employees to develop himself/ herself by acquiring new knowledge and skill.
   1.Disagree 2.Neutral 3. Agree

3. Add Communication
   1. Suggestion box 2. HR Dept/ Hospital Administrator 3. HODs

B. COOPERATION

4. Team work is highly encouraged in this hospital.
   1.Disagree 2.Neutral 3. Agree

5. Day-to-day problems are discussed openly with the objective to solve them rather than blaming each other behind the back.
   1.Disagree 2.Neutral 3. Agree

6. Your seniors take active interest in helping you and other juniors learn job.
   1.Disagree 2.Neutral 3. Agree

C. TRAINING

7. When employees are sponsored for training, they take it seriously and try to learn from the programmes they attend.
   1.Disagree 2.Neutral 3. Agree

8. Employees returning from training programmes are given opportunities to try out what they have learnt.
   1.Disagree 2.Neutral 3. Agree

D. PERFORMANCE FEEDBACK

9. Employees in this hospital obtain feedback about their strengths and weakness from supervising staff.
   1.Disagree 2.Neutral 3. Agree

10. When performance feedback is given to employees, they take it seriously for their development.
    1.Disagree 2.Neutral 3. Agree

11. There is a policy in this hospital to reward good work.
    1.Disagree 2.Neutral 3. Agree

12. Employees are very informal and feel free to discuss their personal problems with their superiors.

    1.Disagree 2.Neutral 3. Agree

E. FAVOURITISM

13. Promotion is based on the suitability of the person rather than on favoritism
    1.Disagree 2.Neutral 3. Agree

14. Performance rewards are based on objective/ adequate assessment and not on favouritism.
    1.Disagree 2.Neutral 3. Agree

F. POLICIES

15. Do you feel that the hospital's policies are favourable to you?
    1.Disagree 2.Neutral 3. Agree

16. You are informed earlier of suspension/ dismissal procedures.
    1.Disagree 2.Neutral 3. Agree

G.FAIRNESS OF PAY

17. Your salary is compatible with the prevailing rates in the market.
    1.Disagree 2.Neutral 3. Agree

18. Your experience matters in fixing salary.
    1.Disagree 2.Neutral 3. Agree

19. The present scheme motivates the employees.
    1.Disagree 2.Neutral 3. Agree

H. TOP MANAGEMENT

20. Top management ensures enjoyable work to employees.
    1.Disagree 2.Neutral 3. Agree

21. Top management believes and trusts you.
    1.Disagree 2.Neutral 3. Agree

22. Top management of this hospital identifies and utilizes the employees potential.
    1.Disagree 2.Neutral 3. Agree

23. Given an alternative employment of a similar nature will you leave this hospital ?

1.Disagree 2.Neutral 3. Agree

I. WELFARE MEASURES

24. This hospital ensures various labour welfare facilities for you.

1.Disagree 2.Neutral 3. Agree

J. RETIREMENT PLAN

25. Are you happy with retirement benefits?

1.Disagree 2.Neutral 3. Agree

K. LEGISLATIVE ENACTMENTS

26. Are you aware of Minimum Wages Act of hospital staff?

1.Disagree 2.Neutral 3. Agree

Thank You

APPENDIX-II

Interview Schedule for Management

1. Name of hospital
2. Nature of ownership:
   (1.) Mission (2) Trust (3) Corporate
3. How old is your hospital
   (1.)upto20 yrs (2.)20-40 yrs (3.) 40-60 yrs (4) 60-80yrs (5)80& above

4.Number of employees
   (1.) 150-250 (2) 251-350 (3)351-450 (4) 450& above

5. Do you have a human resource department?
   Y/N
6. Decision making practice prevalent

a. Centralised b. Decentralised

7. Which of the following is /are the basis for recruitment in your hospital?
   a. Work load b. Hospital expansion

8. Which of the following are the basis of selection
   a. Educational qualification
   b. Experience
   c. Education & experience
   d. References

9. What is the selection criteria for

Criteria	Doctors	Nurses	Para-med
Marks			
Experience			
Mks&Exp			
reference			
3&4			
community			
Comm.&5			

10.Are appointment letters given to all the staff while joining?
   Y/N

11. Does the appointment letter contain
   a. Salary details b. Job description

12. Which of the following communication channels are used by
a. management
(i) memos/Circulars (iii) letters
(ii) notice board (iv) others
b. employees
(i) suggestion box
(ii) exit interview
(iii) surveys
(iv) grievance procedure

13. Are all the personnel policies made known to all the employees in writing? Y/N

14. Do you conduct orientation programmes for new recruits.
a. Always b. Sometimes c. Never

15. Do you have in-house training policy? Y/N

16. Which category of employees are sent for training?
a. Doctors b. Nurses c.Para-medical staff

17. Do you conduct a post-training appraisal? Y/N

18. Do you permit such trained staff to administer such new skills in your hospital?
a. Always b. Sometimes c. Never

19. What is the frequency of deputing employees for seminars/conferences?
AO- Anually Once AT – Anually Twice N-Never

Category	Corporate			Mission-run			Society/trust		
	AO	AT	N	AO	AT	N	AO	AT	N
Doctors									
Nurses									
Paramedical									

20. Do you have a formal performance appraisal system.
Y/N

21. If yes, which of the following are the uses of performance appraisal information? (Rank in order)
a. wage /salary revision
b. promotion
c. transfer
d. identify training needs
e. verbal feedback

22. Which of the following criteria are used in your performance appraisal?
    a. Quantity of work
    b. Quality of work
    c. Job knowledge
    d. Regularity at work

22. What are the reasons of labour turnover?
    a. Better job prospects abroad b. Marriage
    c. Better job prospects within India
    d. Others (specify)

23. Which of the following factors do you consider while revising the pay scale of your employees
    a. cost of living b. productivity
    c. prevailing wage rate d. retention
    e. collective bargaining strength

24. Schemes adopted for motivating employees
    a. Financial A- Always S- Sometimes N- Never

Category	Corporate			Mission-run			Society/trust		
	A	S	N	A	S	N	A	S	N
Doctors									
Nurses									
Paramedical									

25. Types of Financial incentives

    Doctors

    Nurses

    Paramedical

    b. b. Non – financially Y/N
    1. Award 2. Certificates 3. Mementoes
    4. Award and Certificate 5. None

26. Which of the following retirement benefits does your employee get?
    a. Provident fund c. Pension
    b. Others (specify) d. gratuity
    e. All f. All with out pension

27. Which of the following causes employee grievances in your hospital?

	Doctor	Nurse	Para medical
Promotion			
Increment			
Salary			
Facilities			
Disciplinary actions			
Leaves			
Others (specify)			

28. Does the trade union play any role in determining salary/wage ?
    a. Always b. Sometimes c. Never

Thank You

APPENDIX-III

List of hospitals selected for the study

Sl.No.	Name of Hospital	District
1.	PRS hospital	Thiruvananthapuram
2.	Cosmopolitan Hospital	Thiruvananthapuram
3.	GG Hospital	Thiruvananthapuram
4.	Sree Ramakrishna Hospital,	Thiruvananthapuram
5.	Sree Uthradom Thirunal	Thiruvananthapuram
6.	Mother and Baby Hospital	Thiruvananthapuram
7.	Fort Hospital	Thiruvananthapuram
8.	Upasana Hospital	Kollam
9.	Benzigar Hospital	Kollam
10.	Holy Cross hospital	Kollam
11.	Shanker's Hospital	Kollam
12.	Arafa Medical mission	Kollam
13.	Fellowship Mission Hospital	Pathanamthitta
14.	Muthoot Hospital	Pathanamthitta
15.	Pushpagiri Hospital	Pathanamthitta
16.	Thiruvalla Medical Mission	Pathanamthitta
17.	Indo-American Hospital Vaikom	Kottayam
18.	Carithas Hospital	Kottayam
19.	Matha Hospital	Kottayam
20.	Mandiram Medical Mission Hospital	Kottayam
21.	Medical Mission	Kottayam
22.	Bharath Hospital	Kottayam
23.	St.John's Hospital	Idukki
24.	Medical Trust Hospital	Idukki
25.	Chazhikkatu Hospital	Idukki
26.	Samaritan Hospital	Ernakulam

27.	Sanjoe Hospital
28.	Carmel Hospital
29.	Lakeshore Hospital
30.	Little Flower Hospital
31.	Mar Baselios Medical Mission
32.	Ernakulam Medical Centre
33.	Lisie Hospital
34.	Lourdes HosptaI
35.	MAJ hospital
36.	Medical Trust Hospital
37.	PVS hospital
38.	Indira Gandhi Cooperative Hospital
39.	Amala Hospital
40.	Jubilee Mission Hospital
41.	Elite Hospital
42.	Metropolitan Hospital
43.	West Fort Hospital
44.	Thrissur Heart Hospital
45.	Cooperative Hospital
46.	Ashwani Hospital