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Human Resource Practices and Commitment of Senior Officials in Health System: Reflections from a Progressive State in a Developing Economy

Sunil Maheshwari
Ramesh Bhat
Somen Saha

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INDIAN INSTITUTE OF MANAGEMENT
AHMEDABAD-380 015
INDIA

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Abstract

It is widely recognised that the commitment and competencies of people working in the health sector has significant bearing on sector performance and its reform process. The current paper attempts to analyse the commitment of the health officials and its implications for HR practices in Maharashtra. The study suggests that the district health officials do not share a strong emotional bond with their department. The state needs to reform its Human Resource Management practices to effectively strengthen the functioning of the health system. The study shows that there is a need to involve senior doctors in staffing decisions that affect their work units. There is a need to develop a proper tribal/remote area posting plan for the health officials, failing which creates a sense of frustration among the health officials. The study also suggests investing in development of multiple strategies for the growth and career development of health professionals. Finally the study advocates the need to develop areas of public private partnership and community participation in making the public health programme successful.

Keywords: Commitment, Health Reform, HR Practices

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1. Introduction

The health system in India faces daunting task of meeting health challenge of growing population. The public health sector, over a period of time, has grown in size and scope to address this challenge. However, the growing managerial and financial complexities in health care system pose problems in effectively meeting these challenges. These complexities have arisen because of shrinking budgetary support due to fiscal constraints leading to gaps in service delivery and secondly because of lower commitment among staffs in health system (Bhat and Maheshwari, 2005; Maheshwari, Bhat and Somen, 2005) and due to lack of coordination and managerial capacity. Human Resource Management (HRM) issues are very important components for effective implementation of health sector programmes and therefore are important components of sector reform agenda. Availability of adequate funds, equipments and people to man and manage the programmes alone may not necessarily lead to successful implementation of programmes and reforms.

There are two well-known weaknesses in the healthcare system in India: lack of availability of trained health personnel in rural areas and inadequate quality of care. Perception of poor health care services often owes to the behaviour of personnel (Lee, 2001). In rural areas such perception drives the population to seek treatment from local traditional healers and private providers. Health sector reforms aimed at addressing these deficiencies have focused on making health systems responsive through local participation and autonomy. These reforms have intrinsically made some fundamental assumptions:

- high organisational commitment of healthcare providers
- high professional commitment of healthcare providers
- adequate skills of healthcare providers

These are important assumptions, as the success of health care reforms will critically depend on their validity. This paper examines the commitment and competencies of doctors working in public health facilities and its implications for health sector reform. The study was carried out among the senior district health officials of Maharashtra, one of the progressive states of India.

2. Maharashtra

According to most recent interstate comparisons, Maharashtra is one of the most progressive states in India. Net State Domestic Product of Maharashtra at current prices for the year 2003-04 was Rs. 2,94,001 crore and the per capita state income was Rs. 29,204. The state accounts for 13.2 per cent of national income at current price (Economic Survey of Maharashtra 2004-05). The state had recently undertaken Health System Development Project with support from the World Bank. The Maharashtra Health Systems Development Project seeks to assist the local government to: (a) improve efficiency in the allocation and use of health resources; and (b) improve the performance of the health care system at the first referral level and selective coverage at the community level (PID 1997). There are three project components. First, the management development and institutional strengthening component will improve the institutional framework for policy development; strengthen the management and implementation capacity at the state, divisional, district, and facility levels; and develop surveillance capacity for major communicable diseases and strengthening Health Management Information System. Second, improving service quality and effectiveness at district and sub-divisional hospitals will renovate/extend district

hospitals and upgrade selected community health centres (CHCs) to sub-divisional hospitals and construct training centres at four remaining district hospitals. The third component, improving access and innovative schemes, will (a) renovate/extend and upgrade clinical effectiveness at 35 CHCs and enhance their outreach functions; (b) improve the referral mechanisms with the primary and tertiary levels and with private health care; (c) promote health services in tribal areas and for disadvantaged groups; and (d) develop a super-speciality hospital as an innovative scheme for closer cooperation between the public and private sectors (World Bank 1998). An overview of the vital statistics of the state is provided in Annexure 1.

3. Literature Review

Commitment is a multidimensional contextual construct. Organisational commitment refers to an employee's loyalty to the organisation, willingness to exert effort on behalf of the organisation, degree of goal and value congruency with the organisation and desire to maintain membership (Bhat and Maheshwari 2005; Porter, Crampon, and Smith 1976; Porter, Steers, Mowday and Boulian 1974). Professional commitment refers to a professional's loyalty to the profession and willingness to exert effort to uphold the values and goals of the profession. Professionals like doctors may do well to provide healthcare out of their concern for the profession alone (Bhat and Maheshwari, 2005).

Allen and Meyer (1990) have proposed a three-component model of organisational commitment: affective, normative and continuance. The affective component of organisational commitment refers to employees' emotional attachment to, identification with, and involvement in the organisation. The continuance component refers to commitment based on the costs that employees associate with leaving the organisation. Finally, the normative component refers to employees' feeling of obligation to remain with the organisation. Affective, continuance and normative commitment are viewed as distinguishable components, rather than types of commitment; that is, employees can experience each of these psychological states in varying degrees. Meyer and Allen (1991) argue that common to these approaches is the view that commitment is a psychological state that (a) characterizes the employee's relationship with the organisation, and (b) has implications for decisions to continue or discontinue membership in the organisation.

The effective implementation of health services requires concern among service providers towards patients, their relatives, peers and other health service providers. Such concern facilitates team working and strengthens cooperative behaviour. Cooperative behaviour is an outcome of professional and organisational commitment (Lee 2001). Hence, quality of care in the health sector is dependent on both professional commitment and organisational commitment.

Based on literature review organisational commitment consistently has been found to be related to employee behaviours, such as:

- job search activities, turnover, absenteeism and, to a lesser extent, performance effectiveness (Angle and Perry 1981; Morris and Sherman 1981; Porter et al. 1974).
- attitudinal, affective, and cognitive constructs such as job satisfaction, job involvement, and job tension (Porter et al. 1974; Stone and Porter 1976).
- characteristics of the employee's job and role, including autonomy and responsibility (Koch and Steers 1978), job variety and task identity (Steers 1977), and role conflict and ambiguity (Morris and Koch 1979; Morris and Sherman 1981).
- interpersonal relations, career growth opportunities, involvement in decision making, professionalism and more organic approach in staffing practices (Maheshwari, Bhat and Saha 2005).

Employees with high levels of organisational commitment provide a secure and stable workforce (Steers 1977). Owing to their high identification with the organisation, highly committed employees willingly accept the organisation's demand for better outputs (Etzioni 1975), thus assuring high levels of performance and task completion (Mowday, Lyman and Robert 1974; Maanen 1975). There is also evidence that employees' organisational commitment relates to other desirable outcomes such as the perception of a warm, supportive organisational climate (Luthans et al. 1992). Hence, commitment leads intrinsic desire among employees to contribute better output to improved services in service sectors; it also reduces the need for external monitoring mechanisms. Committed employees need less supervision to control their behaviour. In the health sector, employees are expected to strengthen organisation's image among customers through cooperative behaviour. The literature on organisational commitment portrays employees with high organisational commitment not only as highly productive (Mowday, Lyman and Robert1974) and satisfied but also highly responsible with high civic virtue (Nico, Agnes and Martin 1999). All these are important prerequisites to ensure provision of adequate quality of health care services. Hence, the importance of commitment of employees can not be overemphasized.

4. Role of Human Resource Practices in Organisation Commitment

Human resource management (HRM) practices like socialisation, hiring practices, career-oriented performance management, open job posting and job transfer practices play critical roles in building employee commitment. Through socialisation processes managers can attempt to foster better employee understanding of organisational values, norms and objectives (Pascale 1985; Maanen and Schein 1979), leading to identification of employees with the organisation (Jones 1986). Similarly, factors such as confirmation of pre-entry expectations (Arnold and Feldman 1982; Premack and Wanous 1985) and role clarity (Morris and Koch 1979) are important at the time of hiring employees to enhance organisational commitment.

Reward systems and forms of pay structures have their own implications on commitment. Long-term benefits and retained benefits like provident fund and pension scheme (also including employee stock options) and tenure-linked bonus are useful in eliciting continuance commitment (Klein 1987; Wetzel and Gallagher 1990). Similarly benefits like medical facilities, educational loans for children, etc. elicit affective and normative commitment.

Performance appraisals that enhance job clarity (Maheshwari, Bhat and Saha 2005) and involve people in the process (Brown and Robert 1994) enhance organisational commitment. Additionally, the purpose of the appraisal process also influences organisational commitment. Appraisal, aimed at developing people, is more likely to induce organisational commitment.

According to social exchange theory, perceived investment in employees' development is positively associated with affective commitment of employees (Lee and Brouvold 2003). On the other hand, training improves the employability of employees and thus when proper career advancement or opportunities to use the learned skills are not provided; there are higher chances that employees may quit.

Promotion and internal recruitment policies help employees to grow from within. This elicits a sense of belongingness among employees and thus, commitment, both emotionally and morally.

5. Research Questions

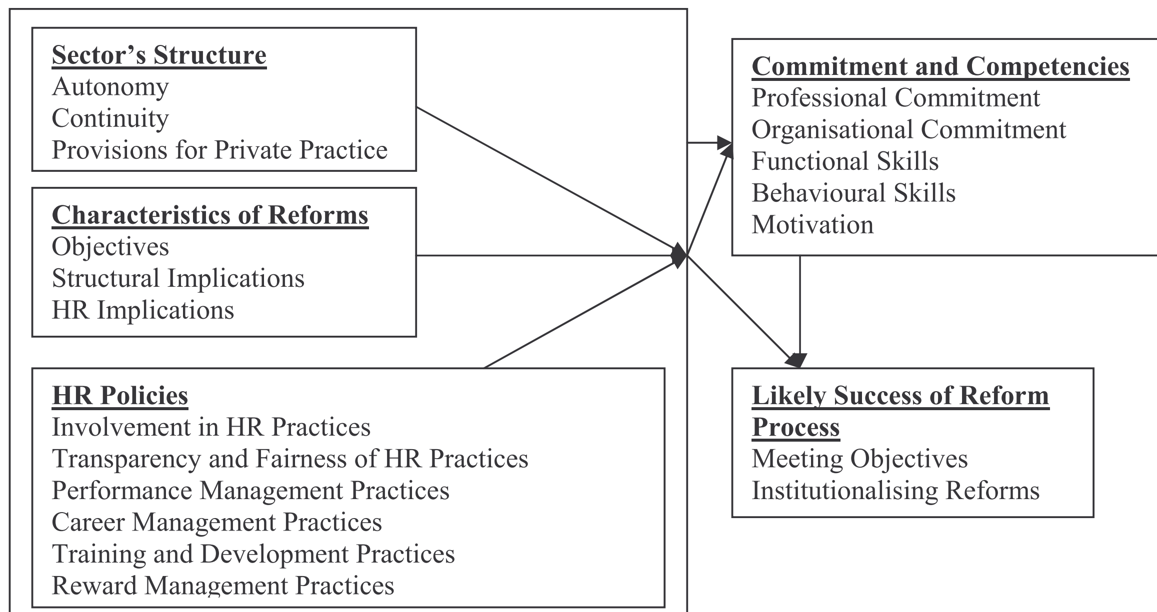
Consistent with the literature review and our earlier experiences with the health officials of Chattisgarh and Madhya Pradesh states of India (Bhat and Maheshwari 2005; Maheshwari, Bhat and Saha 2005), criticality of commitment, competencies and HR practices for reforming the health care sector, this paper examines the commitment of district level health officials in the state

of Maharashtra in India and its relationship with other HR practices. Accordingly, the problem statements were:

- What is status of professional commitment, organisational commitment and technical competencies of health officials in the state?
- What are the characteristics of human resource management practices in the health sector in the state?
- How are these management practices linked with professional and organisational commitment?

Answers to these questions are critical in designing and implementing health sector reforms. The model shown in Figure 1 was used for the study. Commitment scales were developed based on three dimensions: affective, normative and continuance (Meyers and Allen 1991).

Figure 1: Model for the Study



6. Methodology

The study aimed at exploring HR practices in the state and their implications for commitment of health officials. Owing to the exploratory nature of the study, part of the data was collected through qualitative methods, like our previous studies of other two large states in the country. In order to facilitate collection of information not captured through structured questionnaire, scope was made to capture open-end questions towards the end of the questionnaire on areas needing improvement related to human resource practices, constraints and improving working condition of the department. The aim was to understand the factors affecting the work environment of officials in the health system.

To measure commitment and its relationship with HR practice variables, a self-administered questionnaire was used. Based on a questionnaire developed by Bhat and Maheshwari (2005),

and tested among the health officials of Chattisgarh and Madhya Pradesh, the questionnaire was specifically designed to measure the commitment and HR practices of senior officials of health system. The questionnaire included 38 variables with multiple items. The items were measured on a five-point Likert scale. A Likert scale measures the extent to which a person agrees or disagrees with the question. If varies from strongly disagree to strongly agree. While the scales for the questionnaire were developed to measure professional and organisational commitment, technical competencies were measured through professional affiliations of doctors in the state.

The study was limited to district and state officials. It provided the strength of allowing us to study at the strategic level at the top and most crucial operational level: district. It also carries a limitation of having not studied the field units in villages and blocks.

Fifty four district and state health officials agreed to participate in the study. They returned 42 usable questionnaires. Hence, it is likely to be a true representation of the state of HR practices in the state of Maharashtra.

The survey shows that health officials at the district and state level carry rich experience. Their experience in the department and age averaged 24 years and 51 years respectively. Experience in medical profession averaged 26 years.

The characteristics of the sample and mean of different dimensions are provided in Annexure 2. We used Pearson correlation coefficient at two level of significance 0.01 level and 0.05 level in 2 tailed significance test.

7. Findings

The professional commitment of the doctors and the state officials is found to be higher than organizational commitment (Table 1). Our study of three other service organizations shows that organizational commitment has been more than 4.2. It shows that the organizational commitment of doctors and state health officials is on the lower side.

Table 1

Commitment of Doctors at District and State Level to the department and the profession and the differences between them (Scale: 5.00)

	Mean (Scale: 5.0)	N	Std. Deviation	Mean Differences	t
Affective commitment to the department	3.39	42	0.47	-0.54	6.18*
Affective commitment to profession	3.93	42	0.43		
Normative commitment to the department	3.53	41	0.57	-0.32	3.69*
Normative commitment to profession	3.85	41	0.38		
Continuance commitment to the department	3.06	42	0.54	-0.37	3.52*
Continuance commitment to profession	3.39	42	0.55		

** statistically significant at 5 per cent level.*

The higher commitment to their profession drives doctors to execute their professional responsibilities even if their commitment to their departments is lower. The affective organisational commitment is found to range from 2.92 to 3.86 (mean: 3.39). This, and normative commitment (3.53) indicate that district health officials do not share strong emotional bond with their department. Their identity with the department is weak. Consequently, doctors and state officials are unlikely to take many proactive actions and suggest useful ideas. Their willingness

to take initiatives is also likely to be restricted. This also indicates possible lack of cooperative behaviour to encourage and sensitize interdependencies in the department.

Any reform process in the health sector that seeks high involvement of doctors is unlikely to succeed unless issues relating to affective and normative commitment are taken care of. To understand the actions that significantly affect organisational commitment, 2 tailed Pearson correlation coefficient with significance level at 0.01 and 0.05 was carried out. The correlation coefficient with HR practice variables are given in Tables 2 to 4.

The results presented in Table 2 indicate that reform initiatives which ensure adequate advantage to the development climate of the department are more likely to succeed. Reforms to develop motivation to perform support for growth and development, healthy relationship between superiors and subordinates and greater consultation of senior doctors in staffing practices would enhance their commitment to the organization and thus organisational performance and success of the reform process. There is a strong indication that the HR practices on these dimensions in the department are causing frustration among doctors who are getting lesser committed with time.

Doctors who have served longer tenure in clinical setting show lower affective organisational commitment. The concerns of development, involvement in decision making and interpersonal relations need to be addressed on a priority basis.

Table 2

Affective Organisational Commitment	**Pearson correlation Coefficient**
Consultation in Posting	0.37*
Job Clarity	0.48*
Support for Growth and Development	0.54**
Professional Competency Development	0.38*
Training Adequacy	0.43**
Motivation to Perform	0.41**

*** Correlation is significant at 0.01 level (2-tailed)*
** Correlation is significant at 0.05 level (2- tailed)*

Our similar study of health officials of Madhya Pradesh (Maheshwari, Bhat and Saha 2005), suggested that doctors do not want a bureaucratic pattern of staffing decisions. They do not expect postings and transfer to be strictly according to rules. They prefer decisions that are situation-specific, considering skills and other such subjective factors. The department has to examine its decision making to make it more organic than bureaucratic.

On a similar pattern, correlation coefficient results (Table 3) of normative organisational commitment indicate influence of support for growth and development. Promotion policy in the department, transparency in selection, training and career growth opportunities highly improve normative and continuance commitment. The state will have to develop multiple strategies for the growth and development of health professionals.

Table 3

Normative Organisational Commitment	Pearson correlation Coefficient
Job Clarity	0.49**
Opportunity for CME	0.38*
Support for Growth and Development	0.71**
Fairness in Promotion	0.46**
Transparency in Selection	0.55**
Professional Competency Development	0.66**
Training Adequacy	0.62**
Support for Training	0.58**
Freedom to interact with other department	0.42**
Job Satisfaction	0.43**

*** Correlation is significant at 0.01 level (2-tailed)*
** Correlation is significant at 0.05 level (2- tailed)*

Freedom to interact with other departments, job clarity and satisfaction are other important factors that affect commitment of health officials towards their department. Higher the motivation of the officials, higher is their involvement with organisational goals. Hence, the department should consider investing in areas which positively affect the motivation of officials towards their department. Factors which affect the motivation of employees are discussed in more details on the qualitative section of the paper.

Table 4

Continuance Organisational Commitment	Pearson correlation coefficient
Support for Growth and Development	0.44**
Transparency in Selection	0.35*
Freedom to interact with other departments	0.38*
Job Satisfaction	0.38*

*** Correlation is significant at 0.01 level (2-tailed)*
** Correlation is significant at 0.05 level (2- tailed)*

Professional skills

Professional qualifications of senior doctors in the state are high. More than three-fourth of doctors are postgraduates with specialisation in different fields. These are likely to have contributed to their professional commitment. However, visits to different health care facilities indicated that professionally qualified doctors frequently are not able to utilise their technical capabilities owing to lack of infrastructure. Even qualitative response from the health professionals substantiated the hypothesis. Such practices lead to erosion of professional competencies of the health officials.

Growth of professional competencies is found to be positively related to intrinsic desire among doctors for assuming higher responsibilities and work-role. In spite of the fact that the World Bank supported Health System Development Project have invested in training and medical education of health officials, the same was not reflected in either organisational or the professional variables. Lack of correlation between opportunity of CME and commitment is not well understood and it requires further analysis on the training methodology and other variables.

The result further suggests that empowerment and consultation significantly affects the professional commitment of senior health officials (Table 5 and 6).

Table 5

Affective Professional Commitment	Pearson correlation coefficient
Consultation in Planning	0.32*
Job Clarity	0.38*
Professional Competency Development	0.36*

*** Correlation is significant at 0.01 level (2-tailed)*
** Correlation is significant at 0.05 level (2- tailed)*

Table 6

Normative Professional Commitment	Pearson correlation coefficient
Consultation in Planning	0.41**
Empowerment	0.41**
Importance of CME	0.39*

*** Correlation is significant at 0.01 level (2-tailed)*
** Correlation is significant at 0.05 level (2- tailed)*

8. Findings: Sector Design and Work Environment Implications

Structural arrangements of the sector and developmental of HR practices can lead to required service capability in the health sector. Based on the findings, the following elements of structural design need immediate attention of policy makers.

Technical support from colleagues and superiors

It is well documented that cooperation and coordination from superiors and colleagues have significant role in enhancing the levels of affective organisational commitment of professionals. The findings of this study suggest mixed evidence of cooperation among colleagues and superiors. In situations where there are greater value and importance attached to status and hierarchy in the department, the openness and transparency in sharing and supporting each other at various levels on various health sector related reform issues may be less.

Like in many other states in India, the public and private health providers co-exist in Maharashtra. As a result many state governments in India have allowed doctors in the government health service to do private practice. This has implications for creating competition in the sector as doctors are likely to enhance their professional interests. In health sector the competition generally does not work effectively. Therefore additional efforts are required to develop strong cooperative and collaborating work culture and behaviour among the doctors. This can be done by developing mechanisms which promote extensive socialisation among the doctors. This also helps to indoctrinate professional values and intended departmental culture. Such strategies should be taken up by the department to help doctors cooperate and collaborate with each other. Such value based socialization mechanisms have been found to strengthen strong coordination and control mechanisms in many large and decentralised organisations (Maheshwari 1997). It has also been found that socialisation mechanisms significantly enhance the commitment of people. It is suggested that district level forums could be created where all service providers interact at regular time intervals to facilitate effective implementation of reforms and resolution of issues.

Roles, responsibilities and structural rigidities

The role clarity in any organisation is important. However, there are mixed evidence on the implications of having role clarity on commitment of people working in organisation. In health sector, the doctors at district level generally have three types of key roles to implement programmes and health schemes. These are regulating and monitoring, provision of healthcare services and facilitating and coordinating provision of services (Bhat and Maheshwari, 2004). The three roles require different behavioural patterns. These are summarised in Table 7.

These three different roles of district health officials require three different patterns of behaviour. We observe significant differences in performing these roles effectively at the district level. The field level observations suggest that these roles can not be carried out effectively unless health officials are given adequate flexibility in decision making, autonomy and empowerment. The studies suggest that empowerment and autonomy in decision making is likely to have significant influence on ensuring commitment. Given that health officials at district level have very little autonomy and flexibility in decision making the focus of officials in implementing the programmes and schemes remains more as regulatory in nature. Because of this, the healthcare system is more as having offices which function as islands without smooth communication between them and having rigid hierarchies (Bhat and Maheshwari 2004). Coordination and communication between centre, state, district, sub-division, blocks, sectors and villages is low. There is highly unpredictable resource flows, high variability in performance and inconsistent practices in various operating units. Further the health system gets fragmented owing to lack of integrating mechanisms between health, family welfare and other programmes.

Table 7

Roles and responsibilities in Health Sector

Activities	Regulation	Service Delivery	Facilitating the Services
Goals and objectives	Implementing the laws and standards to protect the health of people like laws related to adulteration of food articles	Caring the patient	Coordinating between personnel responsible for different health schemes
Expected Behaviour	· Authority driven · Top-down communication · Paternalistic · Bureaucratic behaviour	· Influence driven · Bottom-up communication · Benevolent leadership · Pro-social behaviour	· Coordinating abilities · Both-way communication · Customer sensitive
Supportive structure	· Centralised decision-making · High power distance between different levels · Long hierarchy	· Empowerment at lower levels · Low power distance between different levels · Short hierarchy	· Democratic decision-making · Equitable power distribution · Medium hierarchy
Assumptions behind the structural design	· Do not trust people unless proved worthy of that · Do not leave things to chance	· Trust people unless proved unworthy of that	· Neither trust not mistrust, be open to examination every time.

Source: Bhat and Maheshwari, 2005

It is well known that the referral system requires a network of sustained relationships at various levels. They need to be focused on to solve and address problems as they arise and need to be linked by informal channels of communication and networking. At the micro level healthcare providers need to connect, communicate, and collaborate through a web of interrelated informal and formal networks. Low level of commitment and tight structural arrangements and various rigidities fail to facilitate such communication required to provide good and effective healthcare services.

Over the years, the low level of commitment has perpetuated structural rigidities and discontinuities and this as a result has led to mechanistic and inflexible systems of decision-making in the health sector. This makes the system less responsive to the needs of the communities. This has also led to situation where we find that, over the years, decision making in health sector to a large extent has become highly centralised. This centralised decision-making has seriously affected the creativity and commitment among health care providers in the system.

Staffing in health sector

The most striking feature of staffing is the high desire (score: 4.37) among health officials for consultation in planning (Table 8). They want to be consulted whenever an employee is posted in their department. However, the intensity of consultation is substantially low (2.85 in human resource planning). Similarly health officials view unfair practices and lack of transparency in selection process and staffing decisions (score: 2.70). Similar findings were noted in a study of Human Resource Issues for Health sector in the state of Chattisgarh and Madhya Pradesh (Bhat and Maheshwari 2005; Maheshwari, Bhat and Saha 2005).

Table 8

Staffing Practices		
Staffing Practices	**Mean (Scale: 5.00)**	**Std. Deviation**
Consultation in planning	2.85	1.28
Importance of consultation in planning	4.37	0.61
Fairness in transfer	2.83	1.06
Transparency in selection	2.70	0.87
Fairness in staffing decision	2.86	0.86

Participation in human resource planning and staffing develops a sense of understanding and belongingness. The department can secure commitment of their staff by involving them in human resource planning. Similar responses were echoed in the qualitative section of the study.

Since decision-making in the state is highly centralised, staffing decisions are influenced more by political and administrative concerns than field requirements. This is reflected in extremely low perception of fairness in staffing decisions (score: 2.86).

Professional Growth and Career Development

Professional growth and career development opportunities have significant impact on the commitment of doctors. Recently the state has invested on the same through Health System Development Project with support from the World Bank. Opportunities for career growth are on the higher side (score: 3.46) in the state (Table 9).

Table 9

Career Management and Professional Growth Practices		
Career Management Practices	**Mean (Scale: 5.00)**	**Std. Deviation**
Opportunities for CME	3.46	0.82
Support for growth and development	3.30	0.91
Seniority based promotion	3.25	0.98
Fairness in promotion	2.67	0.87
Professional competency development	3.09	0.94
Linkage to seniority based promotion	3.17	0.97

However in spite of investment in career development, doctors do not perceive greater fairness in the system on promotion (score: 2.67) and are of the view that the system still follow seniority based promotion (score: linkage to seniority based promotion 3.17). There is a demand from the officials to link promotion to performance.

Reward Policies

Doctors perceive that there is no relationship between performance and rewards. Hence, the motivation to perform is still low (score: 2.97) compared to the investment in the state on health sector. Rewards do not motivate doctors owing to low perception of fairness and equity. The low scores also adversely affect the accountability of doctors. This finally leads to performance less than satisfactory.

Table 10

Reward Policies and Practices		
Reward Policies and Practices	**Mean (Scale: 5.00)**	**Std. Deviation**
Motivation to perform	2.97	0.76
Reward performance relationship	2.54	0.93

9. Findings: Reflections from Practitioners on Performance

To understand the issues which directly or indirectly affects the commitment and motivation of health officials, but were not addressed properly through a structured questionnaire format, provision were kept for open-ended response towards the end of the questionnaire. The open-ended questions were sought broadly on five variables: positive aspect of the department, negative aspect in the department, constraints to perform in the department, ways to improve the working in department and human resource issues that need immediate attention. The responses from the practitioners were over-whelming and returned a wealth of information. The idea over here is to flag the key issues raised by the practitioners on their department and work environment and try and draw areas which need immediate attention. Hence, no statistical analyses were done on the data.

Strengths and Weakness of the organisation from practitioner's perspective: The practitioners feel proud to be associated with their organisation on a number of aspects. Some of the key dimensions which make them positive towards their departments are nobility of the profession, recognition in society, community orientation in service, preparedness during emergency and disaster, up-gradation of infrastructure under health system development project, efficient system to monitor the health indicators, job security and residential quarters.

Interestingly, some practitioners view the presence of a trained public health professional at the apex decision making level to be a positive attribute towards their department. These attributes binds the professional towards their department and make them proud to be associated with a profession. These responses are presented in Table 11.

However, like any other profession, there were grey areas in the health department, which were reflected by the practitioners as: inadequate budgetary support, limited budget for IEC activities, complicated administrative procedures, limited authority to control subordinates, unsatisfactory participation of community towards the health programmes, undue influence of local leaders and politicians, lack of inter-departmental coordination and inadequate support on research activities. These reflections suggest among other things two important areas of attention: focussing on individual development of practitioners through support on research training and promoting continuous and constructive dialogue with the community to participate in the public health programme.

Table 11

Positive aspect of Department	Negative aspect of Department
Noble profession – Serving public to reduce MMR, IMR	Inadequate finance
Good team work during emergency/ disaster management	No budget for IEC activities
Community oriented services	Complicated purchase procedure
Uplifting of hospital image due to MHSDP	Insufficient maintenance grants for building
Opportunities for CME	Individual accountability not measured
Job Security	No punishment for non-performance
Adequate infrastructure and logistics	No decision making authority in administration
Recognition	No power to control subordinates
Well planned job	Logistic supply inadequate
Regular review of all indicators	Inadequate public private partnership Community/NGO participation not adequate
Residential quarters to most of Officers	Rewards not linked to performance
Supervision and guidance	No support for research activities or paper presentation
Director General from public health background	Corruption in transfer and promotion policy
Brought down number of vaccine preventable diseases	Communication/ transport seriously affected due to lack of vehicle/ POL
ANMs are doing hard work	Undue influence of local leaders/ politicians
Good MIS in place	Inter-departmental coordination not adequate in health sector

Challenges and Ways to overcome them in an Organisation: Transfer and posting were an area of concern for the health officials. Medical officers have to work for years together in tribal and difficult areas without any preference. Over a period of time they start getting frustrated with the system. Hence, there is a demand for effective policy on posting in tribal areas. Extended downtime of equipments results in higher expenditure on repair and revenue loss. Administrative delay and decision problem in health department needs to be addressed. High turnover resulting from block placement of trainee medical officers for one year affects the working of health department. Health facilities in urban and rural areas need to be provided with software, logistic support and internet facilities to fasten the reporting process and deal with emergency situations.

Regional Deputy Directorate (RDD) were created in the state to fasten decision making process and administration of the region. However, health officials feel that this create dual administration with health department directives have to be seconded by the RDD. There is a scope of improving the internal management practices in the department.

Table 12

Constraints to perform in Department	Ways to improve working in Department
Doctors become frustrated when they are to work in tribal and difficult areas for more years. Proper transfer policy needed to work on tribal and difficult areas	Tribal health policy should be developed and implemented
Administrative constraints, limited power to repair vehicles	Increase in budget for material supply, contingent expenditure for repair
Complicated purchase procedure, delays in material supply	Construction of residential and waiting building
Lack of decision making on time increasing downtime and increasing expenditure on repairs	Decentralisation of administration and financial powers to district administration
Frequent transfers	Transfer on seniority basis and not on 10 % of eligible people who have completed 10 years of services at one place
Interference of political and local leaders	Community participation in planning and implementation of programmes
Inadequate budget and staffs	Proper monitoring and evaluation strategies
No participation in planning	Consultation with fixed staffs while going for any plan
Shortage of instruments	Improving logistic supplies and plans
Working with Medical Officers posted for year – High turnover	Development of first level referral units by posting specialists
Low delegation of power	Decentralisation of births and deaths registration
Lack of facilities for education at PHC	Providing software logistics in rural and urban areas
Dual administration – without concurrence of RDD, health department directives are difficult to implement	Improving internal management practices
Frequent changes in reporting systems and guidelines	Interconnecting state bureau with internet facilities
Consideration is not given to maintenance and sustainability	Fostering effective public private partnership
No voice in programme implementation	Delegation of power to subordinates and consultative planning
Urban infrastructure inadequate	Urban infrastructure to be developed
Inadequate community participation in programmes	Management of hospitals by community
No independent power to reward or punish subordinates	Start contractual services
Corruption in department	Supervision to be strengthened
No team spirit	Employees should be motivated to achieve organisational goals
Liaison between public health, medical education and research department not strong	Strengthening inter-departmental coordination

Human Resource Issues that need Immediate Attention: Human resource issues that demand immediate attention by the health professionals are listed in Table 13. Apart from their professional career development issues, health professionals give high value to ownership, accountability, study tours, knowledge of advanced technologies and foreign tours. Demand for supportive climate and ownership in the system are other important HR issues that needs immediate attention.

Table 13

HR issues that need immediate attention
Individual performance should be evaluated
Promotion based on merit
Fostering strong supportive climate in department
Recognition and job appraisal
Career oriented performance measurement
Incentive system should be introduced
Importance of ownership, involvement of everybody
Decentralisation of power
Training about work culture
Imparting pre-placement training
Impart CME
Clear statement of job responsibility
Build more accountability in work
Rewarding and awarding by study tours
Training in advance technologies
Incentives like foreign tours should be given to all people and not to only certain people

10. Implications

The commitment of people working in the health sector has significant implications for any sector reform process. This study suggests that although Maharashtra being a progressive state and has invested in a large way in its health system development, the sector faces a number of human resource challenges to ensure the professional and organisational commitment of officials. Meeting the health care needs of the population perhaps goes beyond mere budget allocations. Given the growing complexities and challenges the health sector faces, the reform in health system have to be given a more human face. Reforms generally focus on making the health system responsive through higher allocations and strengthening financial systems, ensuring local participation and public-private partnerships, and autonomy of health facilities. *Inter alia* it is through these reforms that deficiencies in the health sector can be addressed. The reform process is also likely to help in developing strategies that ensure effectiveness and efficiency of resource use. However, the reform process makes some fundamental assumptions about the intrinsic organisational and professional commitment and availability of skilled and competent health care professional. Since development-oriented human resource practices are powerful tools that commit health professionals to enhance the quality of care, we believe that health sector reforms should concentrate on human resource issues and practices more than ever before.

Annexure 1

Profile of Maharashtra

Maharashtra is the third largest state of India in terms of area and second largest in respect of population after Uttar Pradesh. The state is bounded by the Arabian Sea in the west, Gujarat in the north-west, Madhya Pradesh in the north and the east, Andhra Pradesh in the south east and Karnataka and Goa in the south. The state leads the country's industrial development scenario and continues to attract the largest quantum of investments, both domestic and foreign. The state accounts for 23 per cent of the gross value of industrial output in the country. The state is divided in 6 revenue divisions and 35 districts. Total population of the state as per 2001 census was 9.67 crore, which was 9.4 per cent of the total population of India. The state accounts for 922 females per thousand males. The per cent of urban population in the state was 42.4 per cent and Maharashtra was second most urbanised state among major states of India after Tamil Nadu. Population density of the state was 314 persons per square kilometre. Vital statistics of the state are mentioned below.

Key Indicators of the State	
Population (in thousands) 2001 census	96,879
Males	50,401
Females	46,478
Scheduled Tribes	8,577
Scheduled Castes	9,882
Area (in thousand sq. km.) 2003-04	308
Revenue Divisions	6
Districts	35
Literacy rate (Percentage)	76.9
Sex Ratio (Females per thousand males)	922

Vital Health Indicators (2002)	
Birth Rate	20.3
Death Rate	7.3
IMR	45
TFR	2.52
MMR	3.1

Health Infrastructure (2003)	
Hospitals	945
Dispensaries	2,019
Primary Health Centres	1,807
Beds in Institutions	92,472
Beds per lakh of population	92

Source: Economic Survey of Maharashtra 2004-05

Annexure 2
Sample Characteristics

	Mean (Scale: 5.00)	Std. Deviation
AGE	51.46	3.54
EXP_P	25.62	3.56
EXP_D	24.24	5.49
Consultation in posting	2.73	0.92
Job Clarity	3.76	0.86
Training Adequacy	3.42	0.77
Support for Training	3.39	0.76
Role in Training of Subordinates	3.07	1.00
Willingness to Assume Higher Responsibility	3.37	0.65
Freedom to interact with other Departments	3.29	0.90
Freedom in Decision Making	3.06	0.87
Empowerment	4.15	0.74
Relationship with Superiors	3.79	0.66
Importance of Financial Return	2.96	0.67
Concern for Fringe Benefits	2.83	0.82
Pay for Ability	3.23	1.03
Importance of CME	3.96	0.43
Importance of interesting work	4.01	0.42
Concern towards hours of work	3.37	0.90
Expectation towards policies and practices	4.20	0.51
Importance of Job Security	3.91	0.72
Nature of Supervision	4.01	0.53
Job Satisfaction	3.50	0.57

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