Chapter- I

Introduction
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INTRODUCTION

Employee job satisfaction has been under academic and scholarly investigation by the researchers for more than a century now. The existence of such studies takes us back to 1911, when Taylor began to study employees and their job duties to develop better ways to train workers. Seven years later, the interest in job satisfaction had clearly arrived when Edward Thorndike examined the link between work and satisfaction in the Journal of Applied Psychology in 1918. The actual curiosity in exploring job satisfaction began with ‘Hawthorne studies’ by Elton Mayo (1933) and works by Hoppock (1935). Although, these two studies were carried out at the same time yet the Hawthorne studies (1927-33) had the most long lasting influence on job satisfaction research.

As a layman understands, the term ‘job satisfaction’ may sound simple and easy to define—‘as one who is satisfied with his/her job’ yet from a researcher’s point of view conceptual problem associated with job satisfaction or what actually job satisfaction means is a matter of debate since there is no clear cut definition or unanimous decision on what is job satisfaction. The more one defines it, the more complex phenomenon it becomes. It is interesting here to quote a comment made by Mumford that—“job satisfaction is a nebulous concept” expresses the nature of difficulties facing the researchers in this field. Continuing in similar vein, she further argues, “The literature on job satisfaction is of equally small help in providing us with an understanding of the concept. There appears to be no all-embracing theories of job satisfaction and work on the subject has been focuses on certain factors thought to be related to feelings of job satisfaction or dissatisfaction at work. Few studies take a
wide and simultaneously survey of a large number of related variables. Job dissatisfaction has been found easier to identify and measure than job satisfaction...Two points emerge clearly from the work that has been done up to date. One is the elusiveness of the concept of job satisfaction—what does it mean? The second is the complexity of the whole subject”. Since, job satisfaction is an uneasy concept therefore, one cannot arrive at its singular perfect definition. It remains a vague concept for two main reasons. First, one cannot comprehend the concept. Second has the reference to its methodological problems, the question of construct validity. Construct validity is deployed to understand how well a test or experiment measures the true theoretical meaning of the concept. In order to further confirm the complexity involved in defining the term, it a worthwhile exercise to list a few definitions or interpretation of the term.

1.1 JOB SATISFACTION

*Oxford Advance Learner's Dictionary* defines the term job satisfaction as, “The good feeling that you get when you have a job that you enjoy”. In other words a feeling of goodness is associated with an enjoyable job. Various researchers have defined the term. Hoppock’s early definition is “any combination of psychological, physiological and environmental circumstances that causes a person to truthfully say, ‘I am satisfied with my job’ ”. He has emphasized psychological, physiological, and environmental circumstances which lead a person to express satisfaction with their job. Schaffer’s interpretation of job satisfaction is one of individual’s needs fulfillment: “overall job satisfaction will vary directly with the extent to which those needs of an individual which can be satisfied: stronger the needs, the more closely will job satisfaction depends on its fulfillment”. Sergiovanni also supports the personal need fulfillment interpretation and draws attention to the evident link
between Maslow's (1954) theory of human motivation based upon a hierarchy of human needs and Herzberg's (1968) motivation-hygiene theory. Lawler focuses on the expectations rather than needs: "overall job satisfaction is determined by the difference between all those things which a person feels he should receive from his job and all those things he actually does receive". However, Locke dismisses both need and expectation and favours values explaining that understanding job satisfaction is possible only through introspection, for him, "job satisfaction may be defined as a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences". He suggests that job satisfaction is a positive or pleasurable reaction resulting from the appraisal of one's job, job achievement, or job experiences. Vroom defines job satisfaction as "affective orientation on the part of individual towards work roles they presently occupy". Vroom focuses on the role of the employee in the workplace. Smith, Kendal, and Hulin define job satisfaction as "feelings or affective responses to facets of situations". Churchill, Ford and Walker have defined the domain of job satisfaction as "all characteristics of the job itself and work environment which people find rewarding, fulfilling, and satisfying, or frustrating and unsatisfying". Kalleberg identifies both job rewards and job values as determinants of job satisfaction, which he defines as "an overall orientation on the part of individuals towards work roles which they are presently occupying". Similarly, Siegal and Lance states that job satisfaction is an emotional response defining the degree to which people like their job. Lofquist and Dawis define job satisfaction as "an individual's positive affective reaction of the target environment...as a result of the individual's appraisal of the extent to which his or her needs is fulfilled by the environment". Spector feels that it has to do with the way people feel about their job. It is extent to which people like (satisfaction) or dislike
Statt defines job satisfaction as the extent to which a worker is content with the rewards he or she gets out of his or her job, particularly in terms of intrinsic motivation. Armstrong refers to the attitude and feelings people have about their work. Positive and favorable attitudes towards the job indicate job satisfaction. Negative and unfavorable attitudes towards the job indicate job dissatisfaction. According to George and Jones job satisfaction is the collection of feeling and beliefs that people have about their current job. People’s levels of degrees of job satisfaction can range from extreme satisfaction to extreme dissatisfaction. People also can have attitudes about various aspects of their jobs such as the kind of work they do, their co-workers, supervisors or subordinates and their pay. Some of the other versions of definition use the terms ‘work satisfaction’, ‘job attitudes’, ‘job morale’ etc., interchangeably which proves lack of a standardized job satisfaction definition.

1.2 DIMENSIONS OF JOB SATISFACTION

Job satisfaction is understood as a uni-dimensional construct i.e. one was either satisfied or dissatisfied with one’s job. Some view job satisfaction and dissatisfaction on two different dimensions. According to them, one may be satisfied or not satisfied with one’s job on the other hand is dissatisfied or not dissatisfied with the job. They attributed job satisfaction and dissatisfaction to different sets of factors known as motivation or hygiene factors respectively. However, there are three important dimensions to job satisfaction:

- Job satisfaction is an emotional response to a job situation. As such it cannot be seen, it can only be inferred.
• Job satisfaction is often determined by how well outcome meets or exceeds expectations. For instance, if employees feel that they are working much harder than others in the department but are receiving fewer rewards they will probably have a negative attitudes towards the work, the boss and or co-workers. On the other hand, if they feel they are being treated very well and are being paid equitably, they are likely to have positive attitude towards the job.

• Job satisfaction represents several related attitudes which are most important characteristics of a job about which people have effective response. These are: the work itself, pay, promotion opportunities, supervision and co-workers. 20

Some argue that job is multidimensional i.e. one may be satisfied with one’s job, one’s pay, one’s workplace etc. As of today job satisfaction is generally recognized as a multifaceted construct that includes variety of both intrinsic and extrinsic job elements. 21 It emerges from above discussion that earlier job satisfaction was understood as a uni-dimensional construct whereas according to recent studies on job satisfaction it is understood as multi-dimensional construct dependent on different set of factors.

1.3 SIGNIFICANCE OF JOB SATISFACTION

The employer should be concerned with the level of job satisfaction in an organization for various reasons viz. job satisfaction is normally linked with a low level of job complaints and work grievances. It is known that satisfied employees are less likely to resort to damage and reactive behaviour. One of the most disregarded aspects of job satisfaction is its relationship with employee’s well-being. A number of studies have revealed those workforces who are satisfied with their jobs are less prone to health hazards. High job satisfaction may lead to improved productivity, less
absenteeism, lower turnover ratio, reduce accident, less job stress and less unionization. Job dissatisfaction produces low morale among workers which is highly undesirable. Significance of job satisfaction may be understood in respect of the following factors:

1.3.1 Productivity

It is understood that there has been a debate over number of years over the relation between satisfaction and productivity. Although, majority of people believe that there is a positive relationship between the two, however, it is not so. According to the research findings the correlation between satisfaction and performance is only 0.14.\textsuperscript{22} There is more evidence to suggest that job performance leads to job satisfaction and not the other way round.\textsuperscript{23} If people receive rewards that have both intrinsic and extrinsic value, they will be satisfied and it would result in greater job performance.

1.3.2 Absenteeism

It seems quite natural that employees' absence from work would be one reaction to a high level of job dissatisfaction. Empirical research has provided only a weak support for the relation between job satisfaction and absenteeism. A meta-analysis of 31 studies found the correlation between job satisfaction and absenteeism to be only 0.09. Researchers offer a number of explanation for this weak relation. One such reason is the measurement of absenteeism, since it is a complex task to measure absenteeism. Second reason is that job satisfaction represents a general attitude, whereas absenteeism is a specific form of behavior. According to them, job satisfaction may play some role in employee absence, but that role is marginal.\textsuperscript{24}
1.3.3 Employee Turnover

Individuals who are satisfied with their jobs are less likely to leave the organization than those who are dissatisfied. Another issue which might expect to be related with job satisfaction is whether people will remain with the current employer. Analysis suggests fairly low average correlation between overall job satisfaction and employee turnover which was 0.23 and 0.16 respectively. This weak correlation may be due to various factors which may influence turnover decisions includes the availability of suitable alternative employment, job satisfaction better predicts actual turnover when local employment is lower. However, job satisfaction obtained a moderate negative relationship with employee turnover in other similar studies.

1.3.4 Union Activities

Satisfied employees are generally not interested in unions. Job dissatisfaction has proved major cause of unionization. The workers join union for the reason that alone they are not capable to make a change which would remove the cause of job dissatisfaction. Job satisfaction without unionism would be very unrealistic. This means if the organizational climate, personnel policies and policies of management seems dissatisfying most workers tend to look up at union officials to settle their grievances.

1.3.5 Safety

Job satisfaction is associated with perception of risk. In hazardous work environment, greater perceived risk is associated with low job satisfaction. This would imply that job satisfaction is linked to safe working while job dissatisfaction is linked with lower job performance and increased accident. This means when
employees are dissatisfied with their jobs, they are more likely to meet with accidents. A basic reason for this is that dissatisfaction sidetracks an individual’s attention from the job in hand and leads directly to accidents. A satisfied worker will always be careful and attentive towards his job, and chances of accidents will be less.

1.3.6 Other Effects of Job Satisfaction

In addition there are a number of other effects brought about by high job satisfaction. Highly satisfied employees are likely to have more positive outlook, have better physical and mental well-being, learn new task easily, have less stress and instability.

1.4 FACTORS AFFECTING JOB SATISFACTION

Job satisfaction can be determined through factors that describe the relationship between employees and organization. Organizational characteristics refer to factors that are perceived to assist or hinder employees in performing their duties. Various researchers have contributed significantly through their research findings on factors affecting job satisfaction and have given various suggestions to boost up the employee’s job satisfaction. Some of these factors are discussed in brief in the following section:

1.4.1 Pay

Wages and salaries play an important role in influencing job satisfaction. This is because of a few basic reasons. Firstly, money plays an important role in fulfilling one’s needs. Secondly, employees often see money as reflection of management’s concern for them. Thirdly, it is considered as a symbol of achievement and source of recognition. Financial rewards to have a significant impact on job satisfaction. Pay is associated with global satisfaction and even more closely with the facet of pay.

8
satisfaction. Money is important to individuals, research has shown that individuals who earn more are not necessarily more satisfied in their jobs. On the other hand, a researcher argues that a lack of empirical evidence exists to indicate that pay alone improves worker satisfaction or reduces dissatisfaction. The author examines that highly paid employees may still be dissatisfied if they do not like the nature of job or cannot enter a more satisfying job. Thus, it is not sure that pay alone can be a factor causing job satisfaction or dissatisfaction.

1.4.2 Promotion

Promotion involves placement of an employee to a position having higher pay, increased responsibilities, more privileges, increased benefits and greater opportunities. Promotion chances considerably affect the job satisfaction because it indicates an employee’s worth to the organization as well as employees takes promotion as ultimate achievement in their career. Thus, in other words, promotion means advancement of an employee to a higher post with greater responsibilities and high salary, better service conditions and thus higher status. Promotion enhances the yield of an organization when an employee climbs a promotion ladder on the basis of his seniority and resultantly he gets an increased wage rate. However, promotion is not considered to be an incentive device, thus the optimal results cannot be generated by promoting the employee in the organization. Dissatisfaction with promotion and training opportunities has a stronger impact on job satisfaction than workload or pay. They conclude that improving pay would have had limited success without better opportunities. Absence of such prospects makes the employees dissatisfied and frustrated. On the other hand, if employees perceive that there are fair chances of promotion in the organization, same will be reflected in increased quality of output, less wastage, lower absenteeism and turnover of employees.
1.4.3 Supervision

Supervisor is a front-line manager who is responsible for the supervision of employees. Supervision is a moderately important source of job satisfaction. Whenever the supervisor is responsive, sympathetic and takes personal interest in employee's welfare there will be job satisfaction. The supervisors, who allow their subordinates to participate in decisions that affect their own jobs, help in creating an environment which is highly favorable to job satisfaction. However, such situation decreases job satisfaction, where supervisors emphasis more on the job performance and people become less important. Workers are generally more satisfied with their jobs when they are more satisfied with their supervision and liked their supervision better when it matched their preferred style. Research appears to be unclear since most research indicates that employees are likely to have high levels of job satisfaction if supervisors provide them with support and co-operation. On the other hand, supervisors who allow their employees to participate in decisions making stimulate higher levels of employee satisfaction.

1.4.4 Fringe Benefits

Fringe benefit include benefits like free life or health insurance, paid holidays, a pension, etc., and is often received by an employee in addition to his/her regular pay. Fringe benefits can be divided into monetary and non-monetary benefits. The impact of fringe benefits on job satisfaction have been examined less frequently, although available research strongly suggests that a positive relationship exists. The employer provides several benefits and services to the employees working in the organization to maintain and promote the employees' favorable attitude towards the work and work environment which is essential in maintaining high motivation and morale. Increasing intrinsic and extrinsic fringe benefits that attract an employee's
attention may subsequently increase their performance and induce higher levels of satisfaction.\textsuperscript{40}

1.4.5 Contingent Rewards

Contingent rewards are appreciation, recognition and rewards for good work. Employee dissatisfaction may result if an employee perceives that their efforts are not recognized or that their rewards are not equitable tied to their performance or tailored to their needs. Contingent rewards support the reinforcement theory of motivation in terms of which performance-relevant behaviours will increase in frequency if rewarded.\textsuperscript{41} Lack of proper recognition for a job well done by an employee seems to be a major problem for many organizations. For example, employees who experience little recognition are more likely to experience dissatisfaction and frustration.\textsuperscript{42}

1.4.6 Operating Conditions

Good working conditions are sought-after by the employees, as they lead to more material comforts. Employees wish for clean and healthy working environment. Temperature, humidity, ventilation, lighting and noise, cleanliness of work place and adequate tools and equipment affect job satisfaction. However, desirable operating conditions may not contribute heavily towards job satisfaction whereas poor working conditions do become source of job dissatisfaction. If people work in a hygienic, friendly environment they will find it easier to come to work. If the opposite happen, they will find it difficult to accomplish tasks.\textsuperscript{43}

1.4.7 Co-workers

A friendly and cooperative group provides opportunities to the group members to interact with each other. It serves as a source of support and comfort to the individual group members. If on the other hand people are difficult to get along with,
the work group will have a negative impact on job satisfaction. An employee would be dissatisfied from his job if he/she is repeatedly exposed to negative statements from the co-worker about their lack of decision making authority. On the other hand, if employee’s co-worker talks positively then opposite happens i.e. greater satisfaction. An employee would feel stronger job satisfaction when their co-workers share similar attitude and values. The factor of relationship with co-workers reflects the extent to which members of an individual's workgroup are perceived to be socially supportive and competent in their own tasks.

1.4.8 Nature of Work

The job condition itself plays a major role in determining the level of job satisfaction. The most important situational influence on job satisfaction is the nature of the work itself—often termed as “intrinsic job characteristics.” Various research studies across many organizations and types of jobs show that when employees are asked to evaluate different facets of their job such as pay, supervision, promotion opportunities, co-workers, and so forth, the nature of the work itself by and large appears as the most important job facet. Of all the major job satisfaction areas, satisfaction with the nature of the work itself—which includes autonomy, job challenge, variety and scope—best predicts overall job satisfaction, in addition to other important outcomes like employee retention. Also, it is not to state that well-planned compensation programs or effective supervision are unimportant; rather, much can be done to influence job satisfaction by ensuring work is as interesting and challenging as possible. Thus, in order to rightly comprehend what causes people to be satisfied with their jobs, the nature of the work itself is on the top for researchers to focus on.
1.4.9 Communication

Communication is defined as exchanging of thought or information between two or more persons to bring about mutual understanding. Modus operandi used for communication includes newspaper, telephones, magazines, meetings conferences and seminars, fax, email and internet etc. There are two types of communication formal and informal channel of communication. Formal channel consist of a vertical track and a horizontal track of communication. The vertical track runs in two directions, upward and downward communication between top of organization structure and bottom. The horizontal track carries communication across the organizational structure between departments and individual on about same level. Communication load is also important variable in assessing the degree of adequacy of information exchange. Communication underload takes place when people think they need or could use more information. Whereas, communication overload happens when people have more information than they can possibly process. Further, the most common complaint in organization is that employees do not get enough communication from underload to overload. However, studies show a positive relationship between communication and employee job satisfaction.

1.5 DEMOGRAPHIC VARIABLES AND JOB SATISFACTION

When considering job satisfaction, demographic variables should also be considered to thoroughly understand the possible factors that lead to job satisfaction and dissatisfaction.

1.5.1 Age

With growing age, people become more mature and realistic. The relationship between age and job satisfaction is a complex phenomenon. The relationship between
job satisfaction and age has been studied extensively over last forty year. Regardless of number of studies a general consensus regarding the relationship between age and job satisfaction has yet to be reached. Numerous studies show consistent linear relationship. Others studies argue that age and job satisfaction may not be related in simple linear fashion. According to these researchers, job satisfaction may decline as the newness of the work diminishes and employees become bored with their work. Over the past two decades the notion of a U shaped relationship between age and job satisfaction has gained importance and has received empirical support.

1.5.2 Education

Many studies have concerned themselves with the relationship between education and job satisfaction. Except for few studies which show positive relationship and the other which show negative relationship, most studies show no relationship between job satisfaction and education. Further, the more educated persons would be more frustrated he/she will be in their routine jobs.

1.5.3 Income

Various studies find a significant positive correlation between emoluments and job satisfaction. Whereas, other studies conclude that none of the commonly studied background variables like income level show any correlation with expressed job satisfaction.

1.5.4 Experience

During the initial stage of employment, new workers tend to be satisfied with their jobs. This period involves developing skills and capabilities. The work may seem attractive just because it is new. Early satisfaction decreases if employees do not receive feedback on their progress and tangible evidence of their achievements. After
spending a few years on job, dissatisfaction begins which is often being brought on by the feeling that advancement in the organization is too slow. Job satisfaction appears to increase after a number of years of experience and improve gradually thereafter. The relationship between job satisfaction and length of work experience parallels the relationship with age.  

1.5.5 Gender

Studies on gender difference in job satisfaction find mixed results. Some studies examine that women in predominantly male workplace are less satisfied with their jobs compared to men. Studies even examined job satisfaction for women and men in gender similar vs. gender diverse organization have found mixed results. Other studies find no gender differences or higher level of job satisfaction in women compared to men.

1.5.6 Occupation Level

Higher the occupational or status level of a job, higher the job satisfaction. Executives express more positive job attitude and feelings than first line supervisors, who in turn are usually satisfied than their subordinates are. The higher the job level the greater the opportunity for satisfying motivators needs. Also, high level job offers greater autonomy, challenge and responsibility. Job satisfaction varies with job category. High job satisfaction is more likely to be reported by entrepreneurs (self-employed persons) and by the people in technical, professional and managerial jobs. The least satisfied employees work in manufacturing and service industries.

1.6 JOB STRESS AND JOB SATISFACTION

Stress is a multi-dimensional concept. It is derived from the Latin word, 'stringere' which means—to draw tight, and was first used in the seventeenth century
to describe affliction and hardship. Stress can be of two types: 'eustress' (good stress) and 'distress' (bad stress). Eustress motivates individuals to strive for more. Eustress can be associated with the feeling of boosted energy and feeling more awake and alert. Distress occurs when an individual experiences/faces uncomfortable situation in which an individual does not have the proper coping mechanism to manage them. Stress affects both ways psychologically as well as physiologically. Stress-related disorders includes psychological disorders or those related with thinking (e.g., depression, anxiety, dissatisfaction, getting angry, tension, memory problem, poor decision making etc.). Stress can undermine the achievement of goals, both for individuals and for organizations (Figure 1.1).

**Figure 1.1: The Problem of Stress**

<table>
<thead>
<tr>
<th>For individual</th>
<th>For the workplace/organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Threats to:</strong></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>Increased absenteeism and turnover</td>
</tr>
<tr>
<td>Well-being/quality of life</td>
<td>Reduced quantity and quality of work</td>
</tr>
<tr>
<td>Functioning/goal</td>
<td><strong>Reduced job satisfaction and morale</strong></td>
</tr>
<tr>
<td>Achievement</td>
<td>Problems of recruitment</td>
</tr>
<tr>
<td>Self-esteem/confidence Personal development</td>
<td>Poor communication and increased conflict</td>
</tr>
</tbody>
</table>

Source: S. Michie, 68.

Stress can also affect individual behaviour especially, one may indulge in taking drugs (alcohol, tabacoo) or may suffer from change in sleeping pattern, social behaviour etc. Other physical symptoms include (e.g. sweating, pains, palpitations, nausea, headaches etc.) (Figure 1.2). It is evident from figure 1.1 and 1.2, that individuals react differently in experiencing stress and becomes helpless to the adverse effects of stress.
Individuals will experience more stress if they lack material resources (e.g. financial security) and psychological resources (e.g. self-esteem, coping skills) and are more likely to be harmed by this stress if they tend to react emotionally to situations.

1.6.1 Factors Causing Job Stress

The place of work plays a significant role in causing stress which originates due to overwhelming job demand and job pressures. There are various sources of stress at work that have been found to be associated with stress and other health hazard risks. These sources can be categorized as those related with social and organizational context and those related with the work content (Figure 1.3). Source of stress which are intrinsic to the job include poor physical work conditions (for example, space, temperature, light), long hours, work overload, time pressure, difficult or complex tasks. Others are related to roles in the organization (viz. unclear
work or conflicting roles and boundaries, responsibility for people). The possibility for career development is an important stress buffer which includes (e.g. over promotion, under promotion, lack of training, and job insecurity).

There are two other sources of job stress: organizational structure and climate and relationships at work. Managers who demands, critical, unsupportive or bullying create stress, whereas good team work and a positive social dimension of work reduces it. A culture of providing good amenities and recreation facilities, involving people in decisions and keeping them informed about what is happening in the organization reduces stress.
On the other hand, organizational changes like relocation, mergers, restructuring or downsizing, individual contracts, etc., is a huge source of stress. Even more, the job demands on the individual in the place of work get to the homes and social lives of employees. Long working hours, working away from home, high levels of responsibility, taking work home, job insecurity, and job relocation—all may badly affect leisure activities and family responsibilities. These probably, damage a good and relaxing quality of life outside work, which is important against the stress caused by work.

Several studies have tried to determine the link between stress and job satisfaction. Many researchers think that physiological stress, psychological stress, and job satisfaction are distinct, but highly interrelated constructs. For example, the ability of employees to properly control and manage their physiological and psychological stresses in performing job may lead to higher job satisfaction in organizations. Organization factors such as workload and working condition have been negatively related with job satisfaction. High levels of work stress are associated with low levels of job satisfaction.\(^50\)

The techniques listed in Figure 1.4 are techniques for managing stress viz. the active coping (fight/flight) and rest phases (habituation). Although, it is true that stress can affect the physical and mental well-being of an individual and also plays an important role in causing job dissatisfaction yet it can be reduced through proper training and management.
Figure 1.4: Techniques for Managing Stress

- **Change**
  - Your situation
  - Physical e.g. noise, telephones
  - Social e.g. support systems
  - Work e.g. amount, pressure

- **Your self**
  - Active coping
  - Habits: eating, drinking, sleeping, smoking, exercise
  - Managing time, priorities, delegation
  - Control: self-monitoring, feedback
  - Cognitive: positive thinking/self talk/imagery
  - Psychological preparation including information reappraisal – perception, interpretation

- **Rest/habituation**
  - Relaxation/yoga/meditation
  - Break/leisure/holidays
  - Exercise
  - Distraction/denial/acceptance

Source: S. Michie, 70.

1.7 HEALTH WORKFORCE: A GLOBAL PROFILE

The World Health Organization (WHO) defines the health workforce as “all people engaged in actions whose primary intent is to enhance health.” Human resource pertaining to healthcare can be defined as the various kinds of medical and para-medical staff responsible for individual and public health intervention. This includes both public and private sectors and different areas of health systems, such as curative, preventive care, personal and non-personal public health interventions, disease prevention, health promotion services, research, management and support services (Figure 1.5).
These healthcare employees includes all men and women who work in the field—not only physicians and nurses, but also public health workers, pharmacists, policy makers, educators, clerical staff, and scientists.

World Health Organization study estimates that there is a total of 59.2 million full-time paid health workers in the world. These healthcare employees includes all men and women who work in the field—not only physicians and nurses, but also public health workers, pharmacists, policy makers, educators, clerical staff, and scientists. The health services represent about two-third of the global health workforce, while the remaining one-third is composed of health management and support workers. About two-third of the health workers are in the public sector whereas one-third in the private sector. More than seventy percent of doctors are male while seventy percent of nurses are female—a marked gender imbalance.

Not only this, today, all countries are facing health workforce challenges. One of the major problems for countries is an overall human resource shortage. The World Health Report, published by the World Health Organization (WHO), drew global attention to the human resource for health (HRH) crisis, displayed by imbalances and
shortages in the health workforce. Overall shortages are due to skewed allocation within countries and movement of health workers from rural to urban areas, from public to private (for-profit and not-for-profit), or to jobs outside the health sector. Other factors include migration, work overload, inadequate growth opportunities, insufficient investment in pre-service training, work environment, infrastructure, technical issues and safety amongst others.\(^{62}\)

Currently, there are 57 countries with critical shortages equivalent to a global deficit of 2.4 million doctors, nurses and midwives and over 4.3 million health workers overall. The greatest shortage occurs in Sub-Saharan Africa and South-East Asia, dominated by countries like India, Bangladesh and Indonesia (Table 1.1). Further adding to dismay, these deficiencies are seen in those countries where there are large numbers of unemployed health professionals, poverty, lack of public expenditure on health, bureaucratic red tape and political interference.\(^{63}\)

| Countries with Critical Shortage of Healthcare Providers (Doctors, Nurses and Midwives) |
|-----------------------------------|---------------------------------|-------------------|------------------|------------------|
| WHO Region                        | Total  | With Shortages | Total stock     | Estimated shortage | Percentage increased required |
| Africa                            | 46     | 36             | 590198          | 817992            | 139                |
| America                           | 35     | 5              | 93603           | 37886             | 40                 |
| South-East Asia                  | 11     | 6              | 2332054         | 1164001           | 50                 |
| Europe                            | 52     | 0              | NA              | NA                | NA                 |
| Eastern Mediterranean            | 21     | 7              | 312613          | 306031            | 98                 |
| Western Pacific                  | 27     | 3              | 27260           | 32560             | 119                |
| World                            | 192    | 57             | 3355728         | 2358470           | 70                 |


There is a growing body of literature showing that health workforce turnover is directly influenced by inadequate compensation, poor working condition such as lack of medical equipment and poor workplace safety. Job dissatisfaction seems common because of various reasons, including low work autonomy, poor salaries,
limited promotion opportunities, limited opportunities for professional development, prolonged working hours etc. Also, there is a lack of complete and reliable data which has made the task of maintaining regular check over the health workforce even more difficult from the global to the national and sub national levels.

Therefore, it is essential that human resource for health is managed and handled very differently from physical capital. A series of high level forums on health viz. “Millennium Development Goals”, the launch of the “Global Health Workforce Alliance”, the WHO flagship publication, the HRH strategy report of the “Joint Learning Initiatives”, the World Health Report 2006: Working Together for Health, the “Resolution of World Health Assemblies” on health workforce development, as well as certain regional partnership mechanisms such as the “Asia-Pacific Action Alliance on Human Resources for Health” are among a cluster of international activities that alerted regional, national, and international policy-makers and stakeholders, including the media, civil society and the general public, to the critical importance of Human Resource for Health (HRH) worldwide.64

1.8 INDIAN HEALTHCARE SECTOR: AN OVERVIEW

The healthcare industry in India includes medical-care providers, physicians, specialist clinics, nursing homes, hospitals, medical diagnostic centers and pathology laboratories. India Brand Equity Foundation in its research on “Healthcare Industry in India” quotes that “The Indian healthcare industry is expected to reach US$ 79 billion in 2012 and US$ 280 billion by 2020, on the back of increasing demand for specialized and quality healthcare facilities. Further, the hospital services market, which represents one of the most important segments of the Indian healthcare industry, is expected to be worth US$ 81.2 billion by 2015. Meanwhile, the Indian pharmaceutical market is expected to grow at a compound annual growth rate
The hospital and diagnostic centre in India has attracted foreign direct investment (FDI) worth US$ 1.40 billion, while drugs and pharmaceutical and medical & surgical appliances industry registered FDI worth US$ 9.66 billion and US$ 523.54 million, respectively during April 2000 to June 2012. Healthcare spending in India accounts for over 5 percent of the country's GDP. Out of this, the public spending in percentage is around 1 percent of GDP.65

Rising health awareness, rising income levels, growth in medical tourism, cost effective surgical services, gradual corporatization of the healthcare sector, boom in health insurance sector, Public-Private Partnership (PPP) in healthcare and a growing elderly population—are all driving factors for this growth. In addition, changing demographics, disease profiles and the shift from chronic to lifestyle diseases in the country has led to increased spending on healthcare delivery. It is an accepted fact that hospitals serve an important function in India’s healthcare system. They provide both in-patient and out-patient services and also support the training of health workers and other research and development programmes.

Hospitals in India can be broadly classified as public hospitals, private and not-for-profit hospitals. Corporate hospital chains provide tertiary healthcare services in large towns and cities. The public healthcare system consists of healthcare facilities run by the central and state government which provide services free of cost or at subsidized rates to the people in rural and urban areas. The presence of public healthcare is not only weak but also under-utilized and inefficient.

According to a report published by ASA and Associates, Aug 2012, “India has only 0.7 beds per 1,000 people, far below the global average of 2.6 beds per 1,000 people. India needs to add 2 million beds to the existing 1.1 million by 2027, and
requires immediate investments of $82 billion to make up for its infrastructure deficit. The country needs $50 billion annually for the next 20 years to meet the healthcare needs of its rapidly expanding population.\textsuperscript{66}

Meanwhile, private sector in India is quite dominant in the healthcare sector. Around 80 percent of total spending on healthcare in India comes from the private sector. Therefore, one can rightly comprehend that inadequate public investment in health infrastructure has given an opportunity to private hospitals to capture a larger share of the market.

1.9 EFFECT OF GLOBALIZATION ON HEALTH SECTOR IN INDIA

Global forces are influencing India’s health sector in many ways. But, what actually globalization means is a matter of debate since there is no clear definition of globalization. The more one defines it, the more complex phenomenon it becomes. Rennen and Martens define contemporary globalisation as “an intensification of cross-national cultural, economic, political, social and technological interactions that lead to the establishment of transnational structures and the global integration of cultural, economic, environmental, political and social processes on global, supranational, national, regional and local levels”.\textsuperscript{67} This definition views globalization in terms of eradication of social, political, or cultural practices from their native places and acknowledges the multiple dimensions involved therein.

The so-called ‘tsunami’ of globalization has indeed affected the health of the individuals and global health system. For health community, globalization offers both opportunities as well as important challenges. As the wave of globalization is on the move, a pertinent question which seems disturbing the minds is its likely impact on the global health situation and whether it will improve or worsen the health of people
all over the world. Answer to this question is quite simple yet complex that globalization has acted both ways, positively and negatively in creating an impact on global health situation. More positive outcome includes rise in income of the poor which leads to improved standard of living, better nutrition, low child mortality, better maternal health and education, and high life expectancy. There is now frequent movement of patients, health workers, pharmaceutical goods and services around the world. It has ensured universal access to cost effective health intervention. There is also improvement in other services which indirectly affect health such as water and sanitation, education, environmental protection and health safety programmes. Medical tourism, corporatization of healthcare, transfer of new medical technology for reducing disease burden, etc., are on the rise.

On the other hand, these global forces can create adverse effects on health as well. This negative effect includes spreading of high risk communicable diseases (HIV/AIDS, TB, SAARS, and SWINE FLU etc.) which are often linked with cross border travel and migration. Other good examples of negative effects are the high incidence of lifestyle diseases viz. cancer, heart diseases, diabetes, trade in tobacco/alcoholic products, food trades, drug abuse, illicit drug and human trafficking, intensifying industrial activities, exploitation of natural resources, excessive use of insecticide/pesticide, environmental pollution, un-disposable medical and industrial waste etc. Further, globalization, if accompanied with low public health expenditure can play havoc with health of the poor in developing countries. All these forces of economic liberalization are found to be working more vigorously in Indian health sector.
1.10 HEALTH WORKFORCE IN INDIA

Human resource for health in India is multifaceted and diverse. They range from carefully trained super-specialists and biomedical specialists at one end to a varied collection of community and household based healers at the other. One half of this is filled up with qualified and trained doctors of allopathic or modern medicine, dentists, radiographers, psychiatrists, a range of para-medical professionals—pharmacists, nurses, laboratory technicians, and a number of allied personnel policy makers, managers and health planners, psychologists, social workers, health educators, researchers, promoters, and health technologists. While the other half is filled with India’s traditional healing system. Here, one finds professionally trained and university qualified practitioners of ayurvedic, unani, homeopathic, siddha and naturopathic medical traditions. One also comes across informally trained providers through apprenticeships, traditional and household birth attendants, bone setters, a variety of folk and magico-religious healers with disease specific specializations, and community or household elders learned in the art of traditional healing and indigenous remedies.

1.10.1 Size and Composition of the Health Workforce

Health workers are classified into the following broad categories—allopathic physicians (including surgeons), nurses and midwives, AYUSH, physicians, dentists, pharmacists, others (include dieticians, nutritionists, opticians, dental assistants, physiotherapists, medical assistants, medical technicians and other medical staff) and other traditional healthcare practitioners (includes traditional medical practitioners and faith healers). India has a doctor: population ratio of 0.5 per 1,000 persons in comparison to 0.3 in Thailand, 0.4 in Sri Lanka, 1.6 in China, 5.4 in the United Kingdom, 5.5 in the United States of America and 5.9 in Cuba. The ratio of 2.19
nurses and midwives per doctor ranks India lower than Sri Lanka (3.94) and Thailand (5.07). Rao et al. (2012) have made estimates of the size of the health workforce using information from the NSSO, the Census as well as Government sources. Their estimate suggests that India had almost 2.2 million health workers which translate into a density of approximately 20 health workers per 10,000 populations (Figure 1.6).

Figure 1.6: Health Worker Density: All India (per 10000 Population)

Source: Rao et al., 3.

As per the most recent figures reported in the World Health Statistics, the density of doctors in India is 6 for a population of 10,000 and that of nurses and midwives is 13 per 10,000, which represents 19 health workers for a population of 10,000. Calculating the figures, National Health Profile estimates that, number of allopathic doctors possessing recognized medical qualifications (under MCI act) and registered with state medical councils for the years 2011 are 921877 respectively. Number of dental surgeon registered with Central/State Dental Councils of India upto 31.12.2011 were 117825. Total number of registered practitioners of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH Doctors) in India as on 01.01.2011 were 712121. State/UT Wise Number of Registered Nurses 18, 94,968 and pharmacists are 657,230 respectively. Further calculating the percentage, an article published in *Times of India* states that “The total healthcare workforce consists
of allopathic doctors (31 percent), nurses and midwives (30 percent), pharmacists (11 percent), practitioners of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH) (9 percent), and others (9 percent). Not only is this, having materially less women in the healthcare workforce adversely affecting women’s access to health care. The percentage of female allopathic doctors is especially low; only 17 percent of all allopathic doctors and 6 percent of allopathic doctors in rural areas are women. This means that there is less than one female allopathic doctor per 10,000 population in rural areas (0.5) whereas it is 6.5 in urban areas. On the other hand, 70 percent of nurses and midwives are women. Nearly two-thirds of all health workers are men. This clearly reflects how far gender imbalance dominates in the existing health sector. India has roughly one nurse and nurse-midwife per allopathic doctor and the qualification adjusted ratio falls further to 0.6 nurses per doctor.

1.10.2 Rural-Urban Distribution of the Health Workforce

The rural-urban distribution of health workers in India is an important issue and it is fully known that the distribution of health workers is heavily skewed towards urban areas. These estimates indicate that overall and across most health worker categories, typically 60 percent of the health workers are present in urban areas whereas only 28 percent of the country’s population is urban. The number of health workers per 10,000 population in urban areas (42.03 percent) is four times than that in rural areas (10.78 percent). The number of allopathic physician per 10,000 people is three times larger in urban areas (13.3 percent) than in rural areas (3.9 percent), and as far as nurses and midwives are concerned 15.9 percent of them are in urban areas whereas 4.1 percent are serving in rural areas (Figure 1.7).
More practitioners of ayurveda, yoga and naturopathy, unani, siddha, and homoeopathy work in urban areas (3.6 per 10,000 population) than in rural areas (1.0 per 10,000 population).

1.10.3 Health Workers in the Government and Non-Government Sector

Estimates on the health workers in the public and private sector were available only from the NSSO. Figure (1.8) below indicates that the public sector plays a minor role in providing physician services in both urban and rural areas whereas majority of allopathic physician in rural (90 percent) and in urban (80 percent) are employed by the private sector indicating that India’s health sector is highly affected by the onslaughts of privatization. Allopathic Physicians, AYUSH, and Dentists are also mostly present in the non-government sector in both urban and rural areas. Health workers in other category and Pharmacists tend to be equally distributed between the private and public sector in rural areas, but mostly present in the private sector in urban areas. Other traditional health workers are mostly in the private sector. These
findings confirm that majority of curative care services are being provided by the private sector in India.

**Figure 1.8: Distribution of Health Workforce by Sector**

In contrast, around 50 percent of the nurses and midwives in both urban and rural areas are employed by the public sector. While this shows that the government sector contains a large capacity in providing nursing and midwifery services both in rural and urban areas, these findings are at variance with findings from national surveys which indicate that the majority of attended births takes place in the private sector.\(^{74}\)

Government estimates also suggest that the distribution of health workers is heavily skewed towards urban areas. The National Commission on Macroeconomics and Health also finds the fact that health workforce is highly concentrated in the non-government sector. The Commission conducted a survey in 8 districts to find 75 percent of specialists and 85 percent of technology services in the private sector. The survey also reported that the private sector provided 75 percent of services for dental health, mental health, vascular and cancer diseases and, more significantly, 40 percent for communicable diseases and deliveries. Not only this, seventy-five percent of the specialists are in the private sector. 61 percent anaesthetists, 78 percent cardiologist,
85 percent general physician and 73 percent gynecologist and surgeons, with the majority in above 30 bed category are serving in the private sector.\textsuperscript{75}

1.11 HEALTHCARE WORKERS AND HEALTH CARE INFRASTRUCTURE: A MAJOR SHORTFALL

India’s major limitation has been in the production and distribution of health infrastructure as well as healthcare workers across multiple levels of care. The disparity between requirement and availability of healthcare resources at various levels of healthcare is wide and where they are available are plagued with many problems. The healthcare system lacks a genuine working process of evaluation, monitoring and feedback. Quality assurance at all levels is not adhered to due to bottlenecks in implementation. There is no inducement for those who work well and check on those who do not. There is a lack of convergence with other key areas affecting health, as the system has been unable to mobilize action in areas of safe water, sanitation, hygiene, and nutrition. Along with these constraints there is considerable shortage of public health infrastructure at various levels of healthcare system (Table 1.2).

<table>
<thead>
<tr>
<th>Table 1.2</th>
<th>Shortfall in Health Infrastructure: All India</th>
</tr>
</thead>
<tbody>
<tr>
<td>As per 2011 Population</td>
<td>Required</td>
</tr>
<tr>
<td>Sub-Centres</td>
<td>178267</td>
</tr>
<tr>
<td>PHCs</td>
<td>29213</td>
</tr>
<tr>
<td>CHCs</td>
<td>7294</td>
</tr>
</tbody>
</table>

Notes: All India shortfalls is derived by adding State-wise figures of shortfall ignoring the existing surplus in some of the States.

Maximum shortage at the Community Health Centres (CHCs) is adversely affecting the secondary health care and linkages. There are considerable shortfalls plus a large number of vacant positions of doctors, nurses, and paramedical personnel. Government estimates based on vacancies in sanctioned posts (Table 1.3) indicate that total specialist allopathic doctors are in very short supply in the public sector; 40 percent of sanctioned posts for specialists at community health centers are vacant as well as 25 percent of the sanctioned posts for doctors at PHCs are vacant.

Table 1.3
Shortfall in Health Personnel: All India (as on March 2011)

<table>
<thead>
<tr>
<th>For the Existing Infrastructure</th>
<th>Required</th>
<th>Sanctioned</th>
<th>In Position</th>
<th>Vacant</th>
<th>Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health workers (female)/ANM at Sub-Centres &amp; PHCs</td>
<td>172011</td>
<td>177103</td>
<td>207868</td>
<td>8835 (4.98%)</td>
<td>6555 (3.81%)</td>
</tr>
<tr>
<td>Health workers (male) at Sub-Centres</td>
<td>148124</td>
<td>83241</td>
<td>52215</td>
<td>35123 (42.19%)</td>
<td>95909 (64.74%)</td>
</tr>
<tr>
<td>Heath Assistants (female)/LHV at PHCs</td>
<td>23887</td>
<td>23182</td>
<td>15902</td>
<td>7870 (33.94%)</td>
<td>9093 (37.82%)</td>
</tr>
<tr>
<td>Heath Assistants (male) at PHCs</td>
<td>23887</td>
<td>22964</td>
<td>15622</td>
<td>8098 (35.22%)</td>
<td>9935 (41.59%)</td>
</tr>
<tr>
<td>Doctors at PHCs</td>
<td>23887</td>
<td>30051</td>
<td>26329</td>
<td>7246 (24.11%)</td>
<td>2866 (11.99%)</td>
</tr>
<tr>
<td>Nursing staff at PHCs &amp; CHCs</td>
<td>57550</td>
<td>63325</td>
<td>65344</td>
<td>13217 (20.87%)</td>
<td>13262 (23.04%)</td>
</tr>
<tr>
<td>Total specialist at CHCs (Surgeons, OB&amp;GY, Physician, and Pediatrician)</td>
<td>19236</td>
<td>9831</td>
<td>6935</td>
<td>3880 (39.46%)</td>
<td>12301 (63.94%)</td>
</tr>
<tr>
<td>Radiographer at CHCs</td>
<td>4809</td>
<td>2806</td>
<td>221</td>
<td>957 (34.10%)</td>
<td>2593 (53.39%)</td>
</tr>
<tr>
<td>Pharmacist at PHCs &amp; CHCs</td>
<td>22696</td>
<td>24460</td>
<td>24671</td>
<td>4775 (19.25%)</td>
<td>6444 (28.39%)</td>
</tr>
<tr>
<td>Lab Technician at PHCs &amp; CHCs</td>
<td>28696</td>
<td>16153</td>
<td>16208</td>
<td>3525 (21.85%)</td>
<td>13611 (47.43%)</td>
</tr>
</tbody>
</table>

Note: For calculating the overall percentages of vacancy and shortfall, the states/UTs for which human resource position is not available, have been excluded. Also, all India shortfall is derived by adding State-wise figures of shortfall ignoring the existing surplus in some of the States.

Similarly, 20 percent of posts for staff nurses and auxiliary nurse midwives at primary and community health centres are vacant. Various sanctioned posts for radiographers, pharmacists, lab technicians and other health workers (both male and female) are lying vacant. The public health sector has also suffered from significant shortages of health workers. At the PHCs/CHCs level, there is a 23 percent shortfall of nursing staff. The corresponding figures for laboratory technicians are 47.4 percent and for pharmacists and radiographers this figure is 28.5 percent and 53.9 percent respectively. There is a 37.8 percent shortfall in the number of health assistants (female) at PHCs, while the number of health assistants (male) is less by 41.6 percent. There is a 1.9 percent deficit in the number of health workers (female) at the sub-centre and PHCs. The number of health workers (male) is short by 64.6 percent at the sub-centre level (Table 1.3).

A consequence of the shortage of health workers is that many people in rural areas and those who are poor in urban areas receive inappropriate or no healthcare. Public sector efforts to recruit and retain health workers are also compromised by institutional factors such as recruitment delays, changes in service rules, the lack of transparency in identifying vacancies, promotions, and transfers and the many court cases related to such matters that state health directorates face.

Many doctors, nurses, and technicians emigrate from India which is also a significant factor which contributes to the country’s shortage of health workers. In an article published in *Times of India* dated May 14, 2012 states that “While India faces an acute shortage of trained medical manpower, as many as 1,333 doctors migrated to foreign shores over the last one year. During the same period, the previous year—from April 1, 2010 to March 31, 2011—1,157 doctors had migrated in search of employment, and between 2009 and 2010, 1,458 doctors went abroad. Indian doctors
emigrating to the West constitute the largest number of foreign trained physicians in the USA (4.9 percent) and the UK (10.9 percent), the second largest in Australia (4 percent) and third largest in Canada (2.1 percent). About 100,000 Indian doctors work in the US and the UK. Further adding to dismay, High Level Expert Group Report on Universal Health Coverage instituted by Planning Commission of India states that “India ranked 52 of the 57 countries facing an Human Resource for Health (HRH) crisis”. Therefore, it is urgently required that India must develop a national human resource policy which not only examines the current status of human resource for health (medical and para-medical) but also issues directions both at state and national level.

1.12 JOB SATISFACTION AND HEALTHCARE WORKERS

Human Resources for Health (HRH) have been ignored during the course of health sector reforms. The World Health Organization, Joint Learning Initiative, Global Health Workforce Alliance and various others international agencies have been focusing attention on health workers, particularly on the pervasive problems with low remuneration, staffing shortages, poor job conditions, and extensive migration. The World Health Organization (WHO) has identified ten major strategies to improve the performance of health workers, including ensuring appropriate remuneration, exercise supportive supervision, ensure adequate information, improve infrastructure and supplies, promote lifelong learning, develop clear job descriptions, support norms and codes of conduct, match skills to tasks, establish effective team management and ensure adequate information and communication. Job satisfaction among healthcare employees is a very important parameter because it not only influences their productivity and motivation but also influences their quality of work, career, health and various other related factors which ultimately lead them to life.
satisfaction. No doubt, that job satisfaction level among health workers will have a
great impact on work efficiency, quality, and success and at the same time on health
related costs. Worldwide, studies shows that not only factors like pay, promotion,
supervision, contingent reward, fringe benefits, working condition, nature of work,
communication etc. have impact on job satisfaction in healthcare workers, but also
various demographic variables (viz. gender, age, level of education, work experience,
level of income) are equally important in affecting job satisfaction level among health
workers. Besides, health workers face increased risk for work dissatisfaction. Stress
and burnouts are major determinants of health workers well-being. Prolonged
working hours, threat of malpractice litigation, exposure to infectious diseases and
hazardous substances, and the constant exposure to dying and death situations
considerably affect their job satisfaction level. According to a report from the
National Institute for Occupational Safety and Health, “Studies indicate that health
care workers have higher rates of substance abuse and suicide than other professions
and elevated rates of depression and anxiety linked to job stress. This elevated level of
stress is also manifest in high rates of burnout, absenteeism and diagnostic errors and
reduced rates of patient satisfaction”.

In Indian context, relatively little empirical information is available. The
public health sector in India has suffered from inadequate investment. This has
damaged the capacity of health workers to deliver high quality care in the public
sector. The unregulated private health sector in India has created work environments
that deliver poor quality healthcare. This situation seems discouraging to those
healthcare employees aspiring to high professional standards. Not only this, an article
published in Express Healthcare brought out the most disturbing facts stating that
“With 3.5 million healthcare workers in India constantly at risk to health hazards,
have we ever thought about the health safety of the doctor or nurse or ward boy who takes care of the patients suffering from HIV, hepatitis or swine flu? Protecting healthcare workers from the many risks they are subjected to is a big challenge for Indian hospitals. Recently, the H1N1 Influenza pandemic had exemplified the shortcomings of the health system in preventing transmission to healthcare workers. Healthcare staff runs the daily risk of contracting life-threatening infections from blood borne pathogens including HIV, hepatitis B and hepatitis C. As often occurs, when infectious disease outbreaks are caused by an emerging agent, healthcare workers is the group that is most affected. According to WHO, 8,098 cases occurred during the SAARS outbreak, and 774 (9.6 percent) people died. Healthcare workers accounted for 1,707 (21 percent) of the cases. Therefore, in the middle of such miserable situation often faced by health workers one can imagine job satisfaction level among healthcare employees working in public and private hospitals in India and more specifically, in Punjab.

1.13 CONCLUSION

Job satisfaction is a subjective concept and it cannot be quantified with exact precision. Understanding job satisfaction is a complex phenomenon since it varies from person to person. What satisfies a person today may not satisfy him/her tomorrow; and what satisfies them at one place might not satisfy them elsewhere. Although, there are many definitions of job satisfaction, yet there is no unanimity about its definition. Many researchers have tried to define the term job satisfaction in their own unique ways. But still the term job satisfaction remains ambiguous and unclear. Earlier job satisfaction was understood as a uni-dimensional construct whereas according to recent studies on job satisfaction it is understood as multi-dimensional construct dependent on different set of factors. High job satisfaction may
play significant role in improving productivity, less absenteeism, lower turnover ratio, reduce accident, less job stress and less unionization. Researchers, whether in a positive or negative way, have examined several factors that have been linked with job satisfaction. Nevertheless, the magnitude of various factors appears to change under different conditions.

Similarly, individual experiences job stress at workplace due to overwhelming job demand and job pressures. Stress affects both ways—psychologically as well as physiologically. This chapter has also briefly outlined an overview of health workforce in India, developments in Indian health sector, effects of globalization on Indian health sector, shortfall of health infrastructure and health workers and importance of job satisfaction among healthcare employees.
Notes and References


5Linda Evans, op. cit. 5.


12T. G. Worrell, op. cit. 2.


21. A. O. Okaro et al., op. cit. 449.


28S.K. Bhatia, op. cit. 102.


35Ibid. 302.


40E. J. Lumley et al. op. cit. 104.
41Ibid. 104.

42Jassem Mohammed Abdulla, op. cit. 79.

43Ian Howard Frederick Bull. “The Relationship between Job Satisfaction and Organizational Commitment amongst High School Teachers in Disadvantaged Areas in the Western Cape”. MA thesis, University of the Western Cape, 2005. 42.


49Jassem Mohammed Abdulla, op. cit. 84.

50See page 266, para 5 of Jerry W. Hedge, Walter C. Borman’s The Oxford Handbook of Work and Aging for a detailed reference to various studies that confirm linear relationship with age and job satisfaction.

51See page 266, para 6 of Jerry W. Hedge, Walter C. Borman’s The Oxford Handbook of Work and Aging for a detailed reference to various studies that confirm non-linear relationship with age and job satisfaction.

52See page 267, para 7 of Jerry W. Hedge, Walter C. Borman’s The Oxford Handbook of Work and Aging for a detailed reference to various studies that confirm U shaped relationship between age and job satisfaction.
See page 37, para 4 and 5 of Saiyadain's *Hrm, 3e* for a detailed reference to various studies that confirm positive, negative and no relation between education and job satisfaction.

See page 38, para 1 of Saiyadain's *Hrm, 3e* for a detailed reference to various studies that confirm positive and no relationship between income level and job satisfaction.


Schultz Duane. op. cit. 134.


Ibid. xvi

Ibid. xviii


Krishna D Rao, Aarushi Bhatnagar and Peter Berman. “So many, yet few: Human resources for health in India”. Human Resources for Health 2012, 10:19.


Planning Commission of India 2011. op. cit. 141.

