CHAPTER III

REVIEW OF LITERATURE AND RESEARCH GAP

This chapter provides a comprehensive overview of existing literature on Human Resource Development and Patient care quality.

3.1 Human Resource Development – A Review

Effective communication between doctor and patient is a predominant clinical function that cannot be neglected. Communication problems in medical practice are both common and vital. For e.g. a significant amount of patients' problems and concerns were not understood by doctors. There was also an association between proper communication and care outcomes. Lack of effective clinical communication skills of physicians act as a major hindrance in sound care delivery. Unfortunately, the present medical education system does not lay much emphasis on improving the clinical communication skills which is a pre-requisite for providing quality care. Hence, there is an urgent need to revise the existing medical education curriculum by including clinical communication skills in order to provide quality patient care (Simpson et al., 1991).

A training program organised on tips to identify and control rheumatic fever and heart disease among a community block in north India involving health workers, school teachers and senior students was found to be very effective in creating awareness and in reducing the magnitude of these diseases in that particular area (Iyengar et al., 1992).

Ford (1993) proposed a series of metrics which may be usefully applied to the HRD bench-marking. These are expenditure on the Human Resource Development activities as a percent of pay roll, average hours spent on the Human Resource Development per employee per annum, average Human Resource Development cost per participant per hour, percent of employees undertaking the Human Resource Development activity per annum, average of positive ratings of the Human Resource Development activities by the participants, average of improvement in on the job performance as a result of participation in the Human Resource Development activities and cost saving and efficiency gains as a result of participation in the Human Resource Development activities.

A case study undertaken by Margaret Patrickson and Janny Maddern (1996) to find out whether there is a changing role for the human resource practitioners in hospitals imply
that decision on staff mix were governed mainly by available funding and the decisions were taken mainly by members of the directorate.


William and Dodd (1998) identified the topical areas in Human Resource Development as creative problem solving, living with change, managing transitions, power influence, bargaining and negotiation, time and stress management, personal communication, conflict management, team building, interpersonal communication and participative decision making.

Zairi (1998) identified a typical organisation as one which has an adequate system of potential appraisal and promotion, performance guidance and development, role efficacy and reward and recognition system and promoted quality orientation. Quality orientation was measured in terms of customer orientation, continuous improvement, total quality, sense of pride and the like.

An emerging challenge for health-care administrators is how to ensure harmony in a multicultural workforce. A cross-cultural study with 48 Australian and 90 Malaysian nurses showed that the perceived content and context work properties contributed differently to job satisfaction. Specifically, for the Australian nurses, the task content attributes were significant determinants of job satisfaction, while only the perceived information cues substantially contributed to the sentimental responses of the Malaysian nurses. Both types of workplace attributes influenced the nurses’ organisational commitment (Pearson and Duffy, 1999).

The four aspects of healthcare human resource management are improving efficiency in the use of human resources, improving equity in the distribution of human resources, improving staff motivation and performance and improving human resources strategic planning capacity in Ministries of Health. The efficiency in the use of human resources can be increased by changing the skill mix of employees and bringing in flexibility in
employment arrangements. The accessibility to healthcare facilities can be improved by making the rural areas more attractive to health professionals. The performance of health professionals can be improved by rewarding their efforts adequately as well as by providing them with required facilities. All these initiatives should be supplemented by proper human resources planning so as to facilitate effective use of human resources in health care (Tim Martineau, 1999).

Appelbaum et al. (2000) revealed that the employees found satisfaction in being able to perform tasks adequately and were more willing to work hard for the overall well-being of the organisation. This not only increases the involvement of the employees at the workplace but also creates interesting and challenging work.

Sanberg (2000) advocated that investment in HRD by organisations contribute to the organisational and individual performances such as high performance, high quality of individual and organisational problem solving, higher organisational commitment and enhanced organisational retention.

A study by Bhattacharyya (2001) indicated there is no tailor-made set of incentives that will motivate Community Health Workers (CHWs) consistently for an indefinite period. Rather a complex mix of various types of incentives and disincentives can be used to keep the community health workers motivated. While monetary aspects like consistent remuneration and assurance of future paid employment motivates CHWs, inconsistent and inequitable remuneration will act as a hindrance. Similarly skill development opportunities as well as recognition received in the community etc. may motivate CHWs while excessive workload, lack of freedom etc. may act as de-motivators. There are community level factors that motivate as well as de-motivate community health workers. So there should be a proper mix of incentives in order to keep the CWCs motivated.

Becker et al. (2001) identified that organisations need to promote such values as openness, trust, initiative, teamwork and collaboration, human treatment of workers, creativity, quality, empowerment, delegation and the like for better results.

Newman et al. (2001) stated that nurse recruitment and retention are complex issues and cannot be discussed in isolation with each other. There are multiple reasons for the high rate of nurse turnover which in turn leads to patient dissatisfaction. Hence, it is important
for NHS to retain nurses in order to ensure patient satisfaction and enhance the quality of care.

Nutley and Davies (2001) noted that continuing professional development has an important role to play in improving learning. There is also a need to pay more attention to collective learning.

Anil and Sachin (2002), in their study stated that there is a lot to be improved by Indian hospitals in terms of management and administration. This study, based on 80 international hospitals suggests that one of the keys to the success of hospitals is effective human resource management which gets productive output from their medical professionals. The study says that even if they spend 10 percent more on employees, they are 50 percent better in performance.

Calvin (2002) in his article highlights the need for hospitals to retain physicians. He also suggests fulfilling the commitments made at the time of signing contract and making their family comfortable etc. as strategies that can prove to be effective in retaining them.

Englehardt and Simmons (2002) identified that incentives and reinforcements can be used to encourage people to adopt changes such as those that may be the subject of Human Resource Development interventions. Pressure to learn often comes from group norms and from a simple awareness of the skills acquired by others and the available opportunities to learn new ways of doing a job.

Graham (2002) suggests that in an era marked by intense competition for talent, investing in people and building human capacity of an organisation are crucial to future success which requires a shift in management thinking – treating staff as assets rather than costs. Growing number of employers are striving to create “workplaces of choices”. Building a strong employment relationship is crucial in developing a good work environment.

Miller et al. (2002) critically examined gender in relation to the “professionalization” of management in the NHS, focusing on the Master of Business Administration qualification and the important role this played in the professional development of managers and clinicians. They highlighted the implications of gender for the NHS and suggested ways in which management education might incorporate gender into curriculum.
Patton and Marlow (2002) considered training as one of the central elements in the Human Resource Development and the organisational learning. The reasons for reluctance to invest in training are the ignorance of benefits, time issues, fear that training will enhance employee mobility and that there is little evidence to indicate that investment in training and development leads to enhanced firm performance.


Edgar (2003) examined the relationship between human resource management and organisational outcomes such as productivity and turnover rate. He identified the positive and significant impacts of the Human Resource Development practices on their employees’ perception of the Human Resource Development climate and quality orientation.

Schmidt et al. (2003) listed the key trends influencing the field of the Human Resource Development. These are the changes in the work patterns and organisation forms, changing definition of where and how work is accomplished, nature of work and how it is organised and structured, establishing the value of Human Resource Development in the organisation, changing global workforce, changing demographics of workers, ethics and professional development, new notions of career and career development, globalization and e-learning etc.

Singh (2003) conducted a survey of 84 Indian firms representing major domestic business sectors ranging from automobiles and auto components to cement engineering, iron and steel, financial services, info-tech and the like. He found that the combined effect of human resource performance index was significant in predicting firm’s performance as well as employee turnover and productivity.

The paper by Benson and Dundis (2003) discusses the applicability of Maslow’s need hierarchy theory for motivating health care professionals. The authors say that in order to motivate the employees, we should make them feel secure, needed and appreciated. If leaders take into consideration the needs of the employees, the new technology provides
them opportunities to meet their needs and if the organisation provides them necessary training, improved employee performance is possible. The Maslow model presents a way for understanding the needs of the individual, the ever-present and growing technology allows for new ways to meet these needs and training makes the workers more secure, can enhance the feeling of belongingness and self-esteem and provides them the opportunity for self-actualization.

Zachariah et al. (2003) discusses the problems of migrant female nurses from Kerala working in Mumbai. About one fourth of the women face problems of one type or other while commuting from hostel to workplace. A fair percent of these women faced exploitation of some kind as well as discrimination from their office boss or colleagues. While more than three fourth of the women were happy with their current job, about half of the women were trying to change it. On the whole, about one fourth of the migrant women from Kerala were not satisfied with their present job. But still, due to severe unemployment in Kerala they had to migrate to other places in search jobs. Factors such as occupation, income, number of working hours, overtime work, and problems that occur on the way to office, the work load and exploitation or discrimination from office colleagues were found to have major impact on the job satisfaction of these migrant nurses.

A study by Kirpal (2004) across four European nations indicated that there is an increased orientation towards a more flexible, skill-oriented and mobile work culture among nurses. At the same time, it is becoming increasingly difficult to retrain nursing staff due to high work pressure, low level of job satisfaction and low remuneration. So these issues have to be effectively handled in order to sustain the motivation level and professional identity of nurses. Simultaneously, the authorities should see that the nurses are able to strike a balance between their core activity of caring for patients and administrative tasks.

An analysis of causes for low level of patient satisfaction with public health services by Chahal et al. (2004) indicated that biasness, impolite communication, casual attitude and insincerity of doctors towards their job were the prime reasons for the low level of satisfaction of patients with the services rendered at public health care institutions.

Arnold Milstein (2004) opines that one of the key requirements to get people to perform is to appropriately incentivize performance. He also feels that pay-for-performance programs can be effective in improving health industry performance which is heavily underperforming at present.
Chen et al. (2004) found that career development programs positively influence satisfaction of the employees with their professional development and productivity. It was found that employee satisfaction was not associated with the use of either job rotation or multi skilling and was actually negatively related to team autonomy.

Jack et al. (2004) opines that what distinguishes the top performing hospitals is the depth and breadth of their commitment. Key elements of a successful strategy includes developing the right culture for quality to flourish, attracting and retaining the right people to promote quality, devising and updating the right in-house processes for quality improvements and giving the staff the right tool to do their job.

Peccci (2004) reiterated that employee satisfaction is highest if employees feel that they have good wages and they are well paid for what they do. He emphasised the quality of work life and non-monetary rewards in addition to traditional increase in basic pay, and variable rewards such as bonus, profit sharing and gain sharing.

Priti Jain (2004) investigated the main critical qualities required to provide efficient public library service. According to her, they are enthusiasm, positive attitude, innovative thinking, achievement, a feeling of self-worth, job security, staff recognition, status, career development, good salary, effective communication, job satisfaction, conducive working environment, delegation of authority, clear job description, and performance feedback etc.

Siswo (2004) discuss the major pre-requisites for Human Resource Development in an organisation. There are four broad set of factors that impact the Human Resource Development climate of an organisation which are corporate factors, workplace factors, external factors and internal factors. Corporate factors comprise of top management support and quality management systems. The work place factors influencing Human Resource Development climate in an organisation includes people, systems and facilities. Apart from these two factors, the internal environment where the trainees work as well as their relationship with their superiors also impact the Human Resource Development climate of an organisation. So the authorities should focus on these aspects in order to develop and maintain a good Human Resource Development climate in an organisation.

Chew (2005) opined that the most popular on-the-job training techniques are coaching which includes job rotation and self learning, whereas the off job training includes role
playing, case study, lectures, seminars, group discussion, leadership training and slide presentations.

Ekta (2005) describes the ten role stresses experienced by doctors namely, Inter-role distance, Role stagnation, Role expectation conflict, Role erosion, Role overload, Role isolation, Personal inadequacy, Self-role distance, Role ambiguity and Resource inadequacy. Stress audits will help hospitals to understand the level of stress experienced by doctors. She also opines that in order to deal with stress, hospitals should arrange training in relaxation techniques and physical fitness or ‘wellness’ programs.

Fadi (2005) feels that there should be a collaborative and coordinated approach to resolve the complex issues of health human resources for achieving the healthcare renewal goals. Successful healthcare reform will depend on the provision of effective, efficient, accessible, sustainable and high quality services by a workforce that is well trained and present in sufficient numbers. Effective management of human resources requires a committed and sustained effort.

Graham (2005) opines that hospitals can become great places to work if the high trusted work culture is promoted. Strong patient and employee centred cultures can make hospitals remarkably successful.

Hospitals as health care organisations are engaged in providing preventive, curative and rehabilitative services. They are a central part of the medical and social structure. The hospital utilizes widely divergent groups of professionals, semi-professionals and non-professionals. It represents high interdependence among services. A hospital’s success is largely dependent on the quality of work of its human resources. The HR role is the most decisive in a hospital as it is more people oriented rather than equipment oriented. However, HR as a function is being appreciated and initiated in the hospital perspective only recently. The doctor’s role in the hospital is becoming complex day by day. With the advancement in diagnosis and treatment for various diseases becoming multifaceted and intricate, stress levels for doctors remain high. In such a situation it is necessary to clearly define and distinguish the roles for doctors so they do not have conflicting expectations from others. The work of nurses causes maximum stress for them. They must be imparted training which result in win-win situations, and which can be carried out by mutual consensus, which reinforces their sense of importance as thinking, contributing members of the hospital (Pestonjee et al, 2005).
A review of existing literature on organisational interventions to improve patient care by Wensing et al. (2006) indicated that professional performance can be enhanced by enrichment of the professional roles of non-physicians (nurses, pharmacists, etc.) and by computer systems both for reminding as well as decision support. Patient outcomes were enhanced by multidisciplinary teams for patient care, integrated care services, and computer decision support systems.

David and Marie (2006) identified the important constituent components of the HRD namely work place learning, training and development employee development (training and education), organisational development, performance improvement, career development, instructional design, theories of learning at individual and organisational level, consulting and formal and informal learning.

Frankel et al. (2006) introduce and describe three initiatives that can serve as a cornerstone for improving reliability in health care organisations, namely a fair and just culture, teamwork training and communication, and leadership walk rounds. They argue that the three initiatives are critical and related requirements for safe and reliable care, and offer many implementation examples.

In a study by Kabene et al. (2006) it was concluded that the link between human resource management and health care delivery is very complex. As health care is ultimately delivered by people, a clear understanding of human resource management issues is required to ensure the success of any health care delivery program. Proper management of human resources is critical in providing a high quality of health care. A refocus on human resources management in health care is essential to ensure effective health care delivery.

James (2006) discusses the key challenges in terms of healthcare human resources in Africa like inadequate number of healthcare providers, low health workers retention rates, mismatch between available worker skills and competencies and those needed, weak HR management systems etc and various strategies to strengthen the HRH position like workforce planning and rationalisation, strengthening human resource information system, improved human resource management, promoting gender equity, etc

Kavanaugh et al. (2006) discusses the factors that influence healthcare professionals’ job satisfaction. Professional experience is the demographic variable most associated with healthcare professionals’ job satisfaction. Age, education and race accounted for only
minor differences in job satisfaction, while gender, functional grouping, and hospital tenure made no difference at all. Race was significantly associated with satisfaction with job safety and with the person’s own job. There is high need to retain the health care professionals to enhance their satisfaction level. This potential loss of talent may be offset with coaching and mentoring.

Karen et al. (2006) found that the high level of staff turnover is typical of the organisations in the regional areas which result in significant shortage and recruitment difficulties. This creates specific challenges to the HRD strategies and practices in terms of maintaining adequate skill levels.

Lermusi (2006) found that meaningfulness of work and job variety are the two areas that value while HR overemphasis the relationship with the supervisors and the recognition that management gives regarding job performance.

Roseanne and Daniel (2006) opines that holistic, person-centered leadership theories that explain and support values-based work cultures are needed to support nurses in the human caring work that they do within the context of complexity.

Satpathy and Venkatesh (2006) argue that the task of ensuring the availability of MBBS doctors and specialists and building capacity for rural health care in India is huge, but achievable. The challenges include shortages, imbalances and low productivity, compounded by insufficient investment, inadequate pre-service training, migration, work overload, freeze in salaries and work environment issues. The solutions for meeting the health care human resource challenge include creation of a sustainable health system by improving the training curriculum and facilities for health workers, coverage strategy should not only address the numeric requirements but also the appropriate skill-mix and outreach to vulnerable people, motivational aspects such as a positive work environment, adequate remuneration/ compensation, career advancement and a supportive health system, adequate compensation and working environment to ensure retention of skilled workers in the health system, advancing competencies through education to develop appropriate attitudes and skills, and creating conditions for continuous learning, linking health care human resource to the NRHM in addressing health workforce issues, and recognizing that solutions for heath workers’ issues go beyond the health sector and are linked to broader fiscal and financing policies and processes.
The need for significant improvements in behaviour and attitude of health manpower and favourable Human Resource Development (HRD) climate is widely recognised in both developed and developing countries as one of the important requirements for the development of suitable manpower in the health sector in order to achieve the goal of health for all. HRD mechanisms like performances and potential appraisal, feedback and performance coaching, career planning, training induction, role analysis and organisational development, etc were considered necessary to develop a good HRD climate (Mufeed, 2006).

A report by the Alliance for Health Reform (2007) suggests that pay-for Performance models generally seek to reward improvements in quality and high performance by hospitals, physicians, medical groups and others. Hence it is very important to motivate the nurses for better performance by appropriately rewarding the nurses through pay-for-performance initiatives.

A study by Argentero et al. (2007) indicates that relationships with colleagues, work organisation, taking care of patients, professional ability and professional growth were the most important factors influencing the quality of work life of health workers in Italy. The study also showed that the present Italian health system that financially rewards the health workers based on health outcomes may adversely affect the wellbeing of the health workers. It also emphasises the need to develop a mechanism to understand the health workers perception regarding the quality of life offered under the Italian health care system.

Based on observations of more than 100 companies’ efforts to remake themselves into better competitors, Kotter (2007) describes eight critical success factors, including forming a powerful guiding coalition, creating and communicating the vision, and empowering others to act on the vision. He also offers two general lessons learned from more successful cases: (1) change process goes through a series of phases that usually require a considerable length of time, and (2) critical mistakes in any phase can have a devastating impact, slowing momentum and negating hard won gains.

Nidhi and Upinder (2007) compared the constituent factors of HRD in Healthcare in the U.S. and India as perceived by doctors, nurses and patients. There were country specific factors as well as factors that were common to both the countries. However analysis showed that it is essential both in India and the USA to devise persuasive methods of
creating awareness and collaborative sense of responsibility among doctors and nurses to voluntarily and steadily reduce the incidence of medical errors through extra care and concern at all stages from diagnosis, tests, medication and surgery to overall health care compliance.

Nidhi and Upinder (2007) discusses about constituent factors of HRD in healthcare in India and U.S. With regard to doctors, 15 factors emerged to constitute HRD namely openness, quality, elements of development, efficiency, competence, IT applications, concern, responsiveness, welfare, consideration, spirituality, effectiveness, relationship, transparency and ethics. Regarding nurses, 13 factors, namely openness, relationship, efficiency, IT applications, ethics, spirituality, quality, competence, elements of development, effectiveness, commitment, recognition and appraisal constitute the factor structure as perceived by them. Regarding Patients, only one factor, that is, openness, was found common between patients in India and in the USA.

Tzafirir and Gur (2007) state that human resource management practices are among the most important drivers of employee satisfaction. Organisational practices are among the most important drivers of employee satisfaction.

Based on data from three qualitative studies of leadership development, McAlearney, (2008) identifies four opportunities for these programs to improve quality and efficiency: (1) increasing the caliber of the workforce, (2) enhancing efficiency in the organisation’s education and development activities, (3) reducing turnover and related expenses, and (4) focusing organisational attention on specific strategic priorities.

Hospital managers in both public and private sectors, as well as clinician and non-clinician managers, feel that people management and self management skills are the most valuable ones for the efficient and effective management of hospitals, followed by “hard management skills” and skills related to the ability to think strategically and specific skills or knowledge related to health care. These findings contradict those of similar studies conducted in more developed nations such as the USA that prioritize hard skills and medical knowledge. It suggests that health management competencies are context specific, and it is therefore inappropriate to adopt a generic approach (Rubin, 2008).

The guidelines by International Council of Nurses (2008) for incentivising nurses suggest that incentives are important levers that organisations use to manage employee
performance. The most successful incentive plans are those that are tailored to the particular context in which they will be implemented. Incentive packages represent an investment through which that vital asset can be protected, nurtured and developed.

The National Workshop on Human Resources and Management of Health Systems conducted in 2008 in Pondicherry discussed elaborately on the issue of staff shortages in various state run health facilities in India. G. C. Chaturvedi, the then Managing Director of National Rural Health Mission (NRHM) stressed in the workshop on the need to have innovative schemes like Rogi Kalyan Samithi which were capable of implementing people friendly schemes. He observed that human resource management is a sensitive issue and the differences should be resolved through discussions (NRHM Workshop, 2008).

The paper by McCabe and Caravan (2008) discusses the key drivers of nurses’ commitment. Key factors influencing commitment of nurses included shared values, strong leadership, teamwork and support from colleagues and line managers etc. Training and development facilities were also regarded as important by nurses. The areas of nurses’ concern included the substitution of clinical responsibilities of nurses with administrative responsibilities. Hence, the authorities concerned should take all possible efforts to ensure the existence of strong leadership, value proposition, teamwork and training facilities at hospitals in order to keep the nurses motivated. They should also ensure that nurses are assigned only clinical responsibilities and not administrative responsibilities.

The results of a study undertaken by Van et al. (2008) indicated that effective use of community based organisations can serve as an important means to educate rural population on the ill effects of HIV/AIDS among low-literate communities. With proper training, ordinary people can be converted into extraordinary peer educators and agents of change in their communities. Hence, such projects can be used to spread awareness about such issues among low-literate communities.

A study by Hyde et al. (2009) reports that healthcare employees expected their employers to provide infrastructure, HR practices and support which they connected with improved performance especially in relation to patient care and service innovations. Effort was put towards ensuring immediate patient care when expectations were unmet, seemingly, because of public service values. Public service values act as a strong determinant of performance as it relates to patients, moderating possible short-term adverse effects of unmet expectations. However, long term effects of unmet needs cannot be moderated by
these values. As such, it is important to meet the expectations of health workers in the long run.

David Bergman et al. (2009) opined that both long-term support groups and a one-week intensive leadership course support healthcare managers in their leadership. Although the methods differ significantly, the leadership programs complement each other. Both leadership programs strengthened the managers in their leadership role, which co-related with their improved attitude to their leadership role after their respective programs.

In the recent years, a number of upcoming issues are posing serious challenges to the small and medium sized enterprises in terms of establishing new enterprises, globalization, high turnover, financial constraints, low motivation among employees, lack of human capital building etc. HRD activities such as training and development, career planning, self-directed learning are essential to ensure better performance and productivity of SMEs. Thus understanding the problems and challenges are fundamental solutions to expand and strategize SME’s towards future progress and growth (Arokiasamy and Ismail, 2009).

Kalita et al. (2009) elaborates on the role of Public Health Resource Networks, a central government initiative on developing a motivated and empowered team of health professionals involved in providing health care services aligned to the local requirements, ensuring universal coverage, equitable access, efficiency and effectiveness. The program aims at developing a pool of qualified personnel for providing health care services. This initiative was introduced as a measure to bridge the severe shortage of trained health care personnel and has received great support from central as well as state government departments like of health, state training institutes, the National Rural Health Mission as well as leading civil society organisations.

Kelly Jackson (2009) speaks about 4 simple ideas to re-engineer HR practices. The first one amongst them is to analyse the HR practices by undertaking an HR audit. A successful HR audit will uncover those compliance risks that can derail an organisation, learn how a company’s practices compare to industry standards and get a host of new ideas to improve your results. The next idea is to develop a strategic HR plan. Whenever a company develops a new HR strategy, it should be supplemented with an HR plan. The next idea is to make use of technology. Every organisation should make use of the most modern technology in order to ensure efficient utilization of its human resources. Another idea is to leverage the company resources. This means to put the available resources to multiple
uses so as to get maximum return on investment. These are some practices that can be adopted to re-engineer the HR practices of a company.

The allocation of resources is a complex problem in health care. In Finland there has been an effort to solve the problems with a program called “Securing the Future of Health Care”. Ensuring access to treatment partially fulfilled the ethical principles of the right to good care, respect for human dignity, fairness, and co-operation and mutual respect quite well. On the other hand, trust, impressiveness, non-partiality in decision making and the right of self-determination were not as well realised. The shortening of waiting lists had caused exhaustion and motivation problems among personnel and in addition, staff shortages were being experienced (Ulla et al., 2009).

A study by Peters et al. in 2010 indicated there were both commonalities as well as differences in the factors impacting satisfaction and motivation of public and private health sector employees. Factors relating to work environment and job content were considered important by health workers across sector. At the same time existence of good employment benefits and recognition of superiors for good work were considered important especially by the public sector employees.

A study by Priyanka et al. (2010) showed that there was a low level of job satisfaction among the healthcare providers under Central Government Health Scheme as all the variables used for measuring it reported low scores. Intrinsic job characteristics like autonomy, recognition of work, amount of responsibility, amount of variety in work were the main factors that influence the doctors’ job satisfaction and therefore their motivation levels which finally impact the overall work output of the healthcare organisation.

A study by Rao et al. (2010) pointed out that multiple factors attributed to the negative attitude of health workers towards rural service in India. It was found that while financial and educational incentives attract doctors and nurses to rural service, the absence of effective retention strategies induces them to go back to urban areas. A sense of frustration caused by lack of infrastructure, support staff, and drugs, a feeling of exasperation due to local political interference and lack of security are the key factors that inhibit health workers from continuing with rural service. Issues such as lack of water, electricity, education facilities for children, and connectivity adds to the dissatisfaction. Therefore, the authorities concerned should implement effective strategies to attract and retain health workers for rural service.
Mc Hung et al. (2010) discusses various high performance work practices like communicating the vision and values and performance information to the employees, decentralized decision making etc. that must be strategically pursued in order to maximise effectiveness.

The NHS staff council’s 2010 guide to performance appraisal clearly highlights the significance of effective performance appraisal and staff development in ensuring improved patient care outcomes. The guide emphasises that the appraisal process should be flexible and tailor-made to meet the requirements of the organisations. The appraisal process should be operated jointly by the appraisers and those subject to it. The guide clearly states that there should be periodic review of effectiveness of the appraisal process. The staff council also points out the need to ensure the simplicity of appraisal process so that the process as well as its outcomes are easily understood by the stakeholders.

The results of a study by Bonias et al. (2010) showed that psychological empowerment components, specifically autonomy, competence and meaning were significant in mediating the relationship between high performance work systems and perception of quality of care among hospital staff. So, high performance work systems should be implemented at unit level so as to positively affect the psychological empowerment and perception about quality of care among hospital employees.

A study by Brunetto et al. (2011) found that supervisor–nurse relationships affect nurses’ perceptions about teamwork, role ambiguity and well-being, though the relationship is different for public sector and private sector nurses. However, of the two groups, private sector nurses were the most satisfied with their supervisor–nurse relationship and teamwork, and had higher perceived levels of both role clarity and consequent well-being.

A study carried out by Akinyemi (2011) regarding the human resource climate in private sector organisations indicated that team building, supervisory skills development and interpersonal relationship skills enhancement are the aspects to be improved in order to improve the Human Resource Development climate of an organisation. A general climate of trust, team spirit and employee empowerment is an integral component of a conducive HRD climate. There also existed significant link between HRD climate and organisational performance. So a positive HRD climate is necessary to ensure employee as well as organisational growth and development.
Carol and Laura (2011) discusses about the role of flexible working hours in enhancing the happiness of healthcare professionals. While a few professionals directly linked flexible working hours with happiness, others did so indirectly. Flexible working, by promoting happiness, gave rise to discretionary behaviour and other desirable performance outcomes.

Employee participation depends on a number of aspects. The absence of committed management support may diminish the participatory climate and lead to less rather than more participation. Second, union involvement is important for the success of employee participation and can improve communication, trust and co-operation. Third, the existence of tangible benefits to management and employees encourages management to provide for involvement and for employees to take up opportunities. Fourth, public policy can influence the presence of employee participation. Finally, community health-care has a history of participation which, in earlier research by the authors reported the highest levels of support for employee participation in Victorian health-care system (Peter O’Donoghue et al., 2011).

Hamlin and Patel (2011) made an attempt to compare the perception regarding managerial effectiveness at British and Romanian public hospitals. The results implied a high degree of similarity in people’s perception of leadership and managerial effectiveness within Romanian and British public hospitals. At both Romanian and British hospitals, managers are perceived to be effective by their superiors, peers as well as subordinates if they exhibited good organisation and planning skills, proactively managed performance and when they solved problems quickly, lead their staff actively, delegated powers adequately and empowered their staff and expressed genuine care and concern for staff when faced with personal difficulties. Additionally, managers were perceived as effective when they took care of the interests and development needs of their staff and involved them in decision making as well as when they adopted an open, personal and trusting approach. On the contrary, managers, regardless of whether the hospitals were Romanian or British were perceived as ineffective not only when they failed to display positive managerial traits but also when they showed a lack of consideration for their staff and hesitated to share vital information with staff members.

Olaf et al. (2011) discusses activities involved in team learning in nursing like gathering, processing, and storing of relevant information to address learning tasks in the team. Linking team-learning activities and team composition not only revealed a potential for
generating insights into team learning across nursing teams but also created a non-explained part of team learning.

The report by Public Health Foundation of India and National Health Systems Resource Center titled ‘Human Resources for Health in India: Strategies For Increasing the Availability of Qualified Health Workers In Underserved Areas’ describes various initiatives that can be adapted for increasing the availability of human resources in underserved areas. Few of the measures that are suggested in the report include compulsory rural service for medical graduates, provision of financial incentives, proper workforce management policies etc. Various forms of public-private partnerships like contracting-in, contracting-out etc. have also been considered as important means of bridging the gap between demand and supply of human resources at public health facilities across the nation(Rao et al., 2011)

The study by Solkhe and Chaudhary (2011) indicated that there existed significant relationship between job satisfaction and HRD Climate. As such it is very important that a positive HRD climate exist in an organisation so as to enhance the job satisfaction of employees which in turn will improve organisational performance. The top management should have a positive attitude towards employee potential development. Organisations should provide opportunities for employees to acquire and utilize new skills. They should be provided with a clear idea about the career path that they can follow as they enhance their skill level. All these will be helpful in enhancing the organisational productivity.

A study by Curry et al. (2012) regarding the leadership experience in healthcare setting in sub-Saharan Africa indicated that the present models of leadership capacity building deal with the need for core technical and management competencies. While these competencies are important, skills related to managing relationships are also important in the sub-Saharan African context. Developing such skills may take more time and a deeper level of engagement and collaboration than what is currently devoted to.

Economically developed countries have recruited large numbers of overseas health workers to fill domestic shortages. Realising the adverse effects this can have on the health status of developing countries, the UK government has introduced ethical guidance in the recruitment of foreign doctors which aimed to at reduce the number of internationally trained doctors getting registered with NHS. But it was found that immediately after the issue of the code there was a sudden increase in the number of foreign doctors registered
with NHS. But in due course, there was a gradual reduction in the number of doctors registered with NHS primarily on account of other legislations and not the ethical code. Hence, we could conclude that the ethical code was not very effective in reducing the registration of internationally trained doctors with the NHS (Blacklock et al., 2012).

3.2 Patient care quality – A Review

The private sector plays an important role in India's health care system. Through a wide network of health care facilities, this sector caters to the needs of both urban and rural population and has expanded widely to meet the increasing demands and challenges. The total health expenditure in India is estimated to be about 6 percent of the GDP of which private health expenditure is 75 percent or 4.25 percent of G.D.P. About 57 percent of hospitals and 32 percent of hospital beds are in the private sector. At present, about 80 percent qualified allopathic doctors registered with medical councils in India are working in the private Sector (Jessani and Anantharam, 1989).

A study by Reidenbach and Sandifer (1990) showed that patients' confidence was the most important factor impacting their satisfaction with a hospital as well as their willingness to recommend a particular hospital. Hence health care service providers should make all possible attempts to increase patient confidence which is possible by delighting patients by providing services that surpasses their expectations.

A study by Nandray (1992) makes it evident that a substantial financial burden of the household is incurred for meeting health care needs. Compared to government expenditure on health, the private household expenditure is nearly 4 to 5 times more. A substantial portion of their income and consumption expenditure is spent on health. Given this socioeconomic situation in the country, purchasing power becomes a crucial factor. As we have seen, the accessibility of the public health service is poor especially in rural areas of the country. The private health sector becomes unaffordable for the vast majority of the poor. Hence, there is a need to question the dominant role of the private health sector and the consequent high health care expenditure.

An analysis of satisfaction of AIDS patients with the nursing care they received by Fusilier and Simpson (1994) showed that terminally ill patients were generally unsatisfied with the quality of care they received. The factors that contributed to the dissatisfaction were manifold. Long waiting time at emergency rooms, the need to repeatedly explain the
details of medication, discriminatory behaviour on part of nursing and support staff including creation of a separate ward for HIV positive patients etc. were the main structural factors that contributed to their dissatisfaction. Nurses’ lack of awareness about AIDS treatment, their reluctance to provide prompt services as well as lack of empathy among nurses also aggravated the dissatisfaction among AIDS patients.

Benbassat and Taragin (1998) opine that the present system for measuring the quality of care has mostly been looked up on with uncertainty by the medical community. These measures have been criticized for their indecisive validity and for focusing on secondary aspects of services. The successful implementation of these methods seems to be related to them being non-intrusive, non-threatening and mutually agreed standards of care. These three features are considered essential for a continuous quality improvement process in health care.

The paper by Uplekar (2000) discusses the role of private sector in health care service provision. Private sector health care is considered ever-present, reaching to everyone, preferred by the people and significant from both economic and health perspectives. At the same time, we cannot overlook the role of public sector in meeting the health care needs of the public. So both the sectors have their own respective roles to play. Both the sectors have their own merits and demerits. So it would be in the best interest of the public that both the sectors take lessons from each other. An ideal health care system would be one which has all the positives of public as well as private sectors and minimum negatives.

The study by Piya et al. (2000) throws light on the deterioration of public confidence on services in public hospitals due to private practice which in turn encourages people to go for private practice.

Charles (2001) argues that the growing importance of “outcomes research” and “evidence based medicine” will lead to a system of healthcare that will be judged by the degree of success in improving the health outcomes and satisfaction of individual patients as well as the health of the public. He also suggests that there will probably be a need for prioritization within healthcare in the recent future.

*It is important that government intervenes through various techniques in the private health sector.* The primary concern is to clearly define the roles of the public and private health sectors. The government should provide basic healthcare services to the people, as
majority of the poor are dependent on it. It just cannot evade this responsibility. In areas where it is not able to provide services, it should collaborate with the private sector. As the goal of the private sector is to earn profit and that of the public sector is to ensure the well-being which is highly divergent in nature, it is a challenging task to ink a partnership between the two sectors (Sunil et al., 2001).

The National Health Audit figures of Karnataka indicates that 76 per cent of health sector revenues come from private sources, of which almost 50 per cent go to private providers and 21 per cent are spent on drugs. Further, 7 percent of out-of-the-pocket household expenditure is used as non-drug expenditure for using government facilities for out-patient and in-patient treatment (Garg, 2001).

The public, private and co-operative health sectors together contribute towards the health care provision in India. All these sectors play significant roles in influencing the health status of the Indian population. But their contributions definitely have some limitations. Indeed, it is fundamentally their inadequacies that account for the partial improvements in the health status of the Indian people. Unfortunately, the chances that the recognition of these snags and their implications will be converted into action and change are very few, given the present complex nature of Indian bureaucracy. On the contrary, the current state is expected to worsen (D’Cruz and Bharat, 2001).

A study by the Achutha Menon Centre for Health Science Studies (2002) showed that government hospitals, except a taluk hospital and a CHC, had scope to serve more patients than what they presently do. The reasons for existence of idle capacity which was as high as 50 percent in certain cases were identified as unfavourable bed-doctor and bed-nurse ratios, undesirable access characteristics and inappropriate use of staff.

Kulkarni (2002) made an attempt to compare the well-performing and not-so well performing CHCs by carrying out a unit cost analysis. It emerged to be a tough task as the available data was highly insufficient and sparse. Primarily there were too many cost items among CHCs to be analysed. Assessing the cost of inputs received from government was another area of concern. However, despite the limitations, the available data were analysed which indicated that neither cost ratio nor cost share was satisfactory, i.e., actual expenditure exceeded or fell far below budgeted expenditure.
Patil et al. (2002) discusses some key facts with respect to the health care scenario of India. He brings out the fact that about 75 percent of health infrastructure, medical manpower and other health resources are concentrated in urban areas where only 27 percent of the population lives. Infectious, transmittable and waterborne diseases such as diarrhea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections predominantly dominate the morbidity pattern, especially in rural areas. However, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents and injuries are also on the rise. To improve the current situation, a paradigm shift from the current ‘biomedical model’ to a ‘socio-cultural model’ is necessary.

The charter on Medical Professionalism issued as part of Medical Professionalism project (2002) speaks about the challenges that the medical profession faces in the new millennium and centres on the increasing disparities among the legitimate needs of patients, the available resources to meet these needs, the increasing dependence on market forces to transform healthcare system and the temptation for physicians to forsake their traditional commitments to the primacy of patients’ interests. To maintain the fidelity of medicine’s social contract during this turbulent time, physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients, but also collective efforts to improve the healthcare system for the welfare of the society.

A study by Mathiyazhagan (2003) showed that private sector has emerged as people’s preferred health care service provider. This choice is significantly linked to the socio-economic status of the rural population. So it is important for policy makers to take a note of the growing popularity of private sector in case of health care service provision. Considering the limitations of the public sector, it is always advisable to promote public-private partnership.

Waitzkin (2003) clearly pointed out that there is severe inadequacy of public finance in the health sector and an instant and significant scaling up of resources is crucial. The excessive burden on household expenditure on health cannot be wished away. Further, it is also clear that there is an urgent need to streamline the budgeting system to make it more functional, amenable to analyse resource-use for taking corrective measures in time and
flexible enough to give the capacity to respond to an emergency or local need. Rules and procedures for actual release of funds, appointment of persons, labour laws, procurement systems, all need a careful review. A greater delegation of funds, aligned with functional needs and responsibilities is necessary. But any decentralization should be done after developing the requisite financial capability and laying down of rules and procedures for accounting systems. Unless such restructuring takes place of the financing and budgeting systems, greater absorption of funds will continue to be difficult.

Jack et al. (2004) summarises the findings on the key ingredients that contribute to the success of quality improvement strategies, based on site visits and interviews with four top-performing hospitals. They describe four key elements for success which are developing the right culture, attracting and retaining the right people to promote quality, devising the right processes for quality improvement and giving staff the right tools for the job.

The WHO as part of the 9th International Conference on Health Promoting Hospitals held in 2004 established standards for hospitals whereby the hospitals are required to have a written policy for health promotion, have to assess the patients’ needs for health promotion, disease prevention and rehabilitation, must provide the patient with information on significant factors concerning their disease or health condition and should have a planned approach to collaboration with other health service sectors and institutions.

Ajit (2005) focuses on the excessive reliance of Indian medical system on western medicine and the need to rejuvenate the traditional health care system that used to traditionally have wide acceptance. He also discusses the role played by the National Rural Health Mission in improving the rural health status. He states that the quality of a health care system has to be judged in terms of health outcomes, especially of the poor people.

As elsewhere in the world, the private sector in India too focuses on maximizing profits; fails to address public health goals; lacks integration with government health services; draws professionals from the public sector instead of supplementing it; and provides improper or poor quality care. It is clear that the need of the hour is to normalize provider markets and correct imbalances that have created an inequitable, incompetent and expensive system. The regulations will need to ensure ethical practices, transparency and
dissemination of information on prices and quality to customers, impose requirements for licensing and accreditation of hospitals, protocols and prices. If these market failures are not urgently and decisively addressed, the health care system will be unsustainable. It is important to acknowledge that considerable resources have been invested by the private sector and thus fresh investment should be need-based. Second, expansion of access to health care should now be through innovative financing strategies such as universal social insurance or subsidized community financing options. However, the success of such a system will be dependent on having comprehensive regulations, the consensus of professional organisations, consumer advocacy forums, institutionalization of quality assurance mechanisms, a responsive grievance redressal mechanism, an administrative capacity and the will to enforce them (Rao et al., 2005).

Avedis (2005) discusses the appropriateness of using outcome of medical care as an indicator of the quality of medical care. The author emphasises the need to use these with caution as it has certain limitations. Another approach to assessment is to examine the process of care itself rather than its outcomes. This is justified by the assumption that one is interested not in the power of medical technology to achieve results, but in whether what is now known to be "good" medical care is applied. A third approach to assessment is to study not the process of care itself, but the settings in which it takes place and the instrumentalities of which it is the product. Here the assumption is that given the proper settings, good medical care will follow.

Sanyal (2005) stated that cancer is going to be a major health issue in near future especially among two classes of population, one among youngsters and second among the geriatric age group. The present infrastructure, both public and private combined, will be inadequate to meet the future needs. There is an immediate need to expand the health care resource base in order to meet the ever increasing need for cancer treatment.

Ways to ensure patient satisfaction, which is the need of the hour is missing in most of present-day healthcare systems. Today the pressure to increase patient satisfaction is surmounting on hospitals. Many hospitals are now using a new category of tools called Interactive Patient Care (IPC) to enhance patient satisfaction. IPC helps hospitals to automate most of the routine activities like patient education, pain assessment etc. The ideal interactive patient care system should be under a single platform as against disparate components which avoid the need for integration and system maintenance. For consumer
directed healthcare to truly succeed, consumers must be personally empowered at the hospital bedside on various aspects from acute-care to ambulatory care to long term care (Michael, 2005).

A study by Thimothy et al. (2006) indicates that it is possible to provide comprehensive HIV care to affected individuals through the present public health care system without incurring much extra cost thereby improving the quality of life of affected persons. The study also emphasises the role of care homes supported by government in the current socio-political context.

George (2006) stated that the challenge in improving patient safety is to reform corporate governance to make hospital boards take their responsibility for patient safety at least as seriously as they take the hospital’s financial condition. The threat of liability is the primary barrier to the development of effective and comprehensive patient safety programs in hospitals. Hospitals have to, in collaboration with doctors, nurses as well as patients make the concept of patient’s right to safety a reality.

Making effective utilization of resources at their disposal, following the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership, giving prime importance to the care and safety of patients, keeping themselves updated with knowledge and skills etc are some of the practices suggested by the General Medical Council, London (2006) for doctors to become good managers.

Ramani and Mavalankar (2006) remarked that building a health care system that is responsive to the specific needs of the community requires decisions that are politically difficult and administratively demanding. Though the economic development has been gaining momentum over the past few years, health care development is at the crossroads. Though some of the government initiatives in health sector has been a success, Indian health system is ranked 118th among 191 WHO member countries in terms of overall health sector performance. Hence, there is an urgent need to find out ways to improve the performance of the Indian health sector.

Risa (2006) observes that though most of the doctors support the idea of patient-centered care, only few of them really practice it. The key to patient centered care is in converting the system from one of acute care to one of chronic care which is possible in communities
where doctors, healthcare professionals and patients look each other in the eye and talk to each other every day.

Studies indicate that a customer who leaves a hospital unsatisfied results in the loss of lakhs of rupees in terms of revenue over the lifetime of the hospital. So every hospital, especially those under private sector tries its level best to satisfy its clients to the fullest. They adopt various techniques to satisfy patients. Proper streamlining of activities in the outpatient department to provide speedy services, providing attractive ambiance as well as physical facilities, appointing committed and dedicated doctors, nurses and support staff, providing proper emergency as well as palliative care services etc. are some of the steps hospitals usually adopt in order to ensure patient satisfaction (Singh, 2006).

The regional consultation on “Improvement of Quality of Maternal Health Services through Implementation of Review on Maternal Death” organised by WHO South Asia regional office in New Delhi from 13 to 15 January 2003 discussed various steps to be adopted to reduce maternal mortality. Dr Uton Muchtar Rafei, Regional Director of WHO Regional Office for South-East Asia (SEARO) stated that notwithstanding the significant progress made in health development in the region, maternal mortality remains unacceptably high. He identified poor quality and limited access to maternal and newborn health services, including essential obstetric and newborn care as a major determinant of maternal/newborn death. He emphasised that most maternal deaths are avoidable if preventive measures are taken and adequate care provided. The conference discussed the need for quality improvement in maternal and newborn health program in order to achieve the Millennium Development Goals specific to maternal and infant health. The high maternal mortality ratios in South-East Asian countries could be attributed to the fact that in many member countries, more than 70 percent of births occur at home, births attended by a skilled birth attendant in some countries is below 20 percent and access to obstetric care for poor women is still very low with an exception to Thailand and Sri Lanka. These two countries have been able to make remarkable progress due to political commitment, investment in training skilled birth attendants (notably midwives) and establishing a referral link between community and health care facilities (Ronsmans and Graham, 2006).

Palani et al. (2007) discusses the various aspects that are valued by different stakeholders of healthcare. Medical practitioners perceive “value” as the important factor in the process
management since doctors are more concerned about society and beliefs. Paramedical staff
perceived “skill” to be the prime factor for managing people rather than “training”.

The Central Bureau of Health Intelligence (2007) recommends that India’s existing
disease burden and the changing demographics and disease profile reflect a critical need
for adding more health workers in order to achieve even modest coverage for essential
health interventions. The state health directorates should have a full fledged HR
department with dedicated staff. There should be some financial incentive for rural
services and states should adopt a comprehensive training policy based on the actual job
requirements.

Usha (2007) discusses the quality management issues like committed leadership, social
responsibility, strategic planning etc. by taking the case of a South Indian hospital. Social
responsibility issues are addressed through free medical camps, cataract eradication
programs and treatment at concessional rates for those who cannot pay full charges. Focus
on patients, other customers and markets are highlighted in the use of patient satisfaction
survey and feedback forms effectively. The business orientation and healthcare focus have
been integrated well in the hospital.

Delivering service quality consistently creates and fosters the feeling of being cared and
lead to patient satisfaction and loyalty. Holistically, how the doctors, nurses and support
staff treat patients affectively, and how patients perceive the quality of care impacts their
satisfaction level. The study has also identified interpersonal experience of patients with
doctors like their helpfulness, friendliness, satisfactory answers for queries, caring attitude
towards the patients and their relatives and friends as significant contributors to the
satisfaction of patients with physicians’ quality. The quality of doctors, nurses, support
staff, administrative staff, cleanliness, atmospherics and technical services are considered
to be the key parameters of patient satisfaction (Chahal, 2008).

Guruswamy et al. (2008) examined the pattern of public spending on health during 1995 to
2006 in India, both at the national and state levels. It was found that public expenditure on
health as a proportion of GDP has remained dormant over the years, and revenue
expenditure accounting for the larger share. Among the states, the comparatively poor
ones were found to be expending more on health, both per capita wise and as a proportion
of GSDP, compared to the richer states. It was seen that government spending on health
had not grown adequately along the path of overall economic prosperity and private out-of-pocket expenditure seemed to be on the rise.

Inappropriate prescriptions do occur due to reasons like excessive reliance on general acute care and short term treatment, passive attitude towards learning and paternalistic decision making. A multi-disciplinary team approach in identifying drug related problems and providing customised medication will lead to better use of medicines. It is being said that the prescribing process should involve more interaction between patients and doctors. Patients’ and doctors’ attitudes influence prescriptions to a certain extent (Anne Spinewine, 2008).

Mayuri et al. (2008) stated that the quality of healthcare services as perceived by patients is determined by seven factors namely, infrastructure, personnel quality, process of clinical care, administrative procedures, safety indicators overall experience of medical care received and social responsibility. Each of these factors plays a crucial role in determining the satisfaction level of customers. These factors are highly interrelated and interdependent and hence cannot be examined in isolation but have to be looked at holistically.

National Health Services, U.K (2008) proposes some good employment practices for employers of specialty doctors like employing all specialty doctors in the spirit of national contract, providing some system for specialty doctors to record their clinical activity etc. which will help the employers motivate the specialty doctors to perform better and meet the norms of regulatory bodies.

Pillai (2008) opines that Kerala enjoys a high status in terms of infrastructure development in India. In addition to infrastructure development, Kerala also has a high level of human development. The author examined the relationship between human development and economic growth. It was found that the human development that Kerala has achieved through infrastructure development has fuelled economic growth which in turn leads to further Human Resource Development. It is also argued that Kerala has still a long way to go in terms of infrastructural development.

The study by Suryanarayana (2008) indicated that Kerala is above the all national level in terms of the level of living, the extent of inequality in consumption distribution in rural and urban regions and proportion of illness treated. Incidence of morbidity is higher in
rural than in urban Kerala. Within Kerala, the southern part is better in terms of levels of living than the northern part. Proportion of illness treated is higher in Kerala than in India.

Gupta (2008) tried to understand the service provider’s perspective on the key constituents of health care service quality based on focus group discussions with various service providers. Based on the discussions, it was concluded that modern state of art equipments, comfortable, clean and appealing physical facilities, neatly and appropriately dressed nurses and support staff, consistent delivery of proper health care services, maintenance of complete and accurate medical history, prompt accessibility of doctors etc were considered as some of the major constituents of health care service quality.

Developing countries around the world are currently struggling to achieve the Millennium Development Goal Five of reducing maternal mortality to one-third between 1990 and 2015. Many health systems are facing acute shortages of health workers needed to provide improved prenatal care, skilled birth attendance and emergency obstetric services which are crucial to reducing maternal death. The World Health Organisation estimates a current deficit of almost 2.4 million doctors, nurses and midwives. Complicating matters further, health workforces are typically concentrated in large cities, while maternal mortality is generally higher in rural areas. Increasingly, policy-makers have been resorting to human resource strategies to cope with staff shortages. These include augmentation of existing work roles; substitution of one type of worker for another; delegation of functions up or down the traditional role ladder; innovation in designing new jobs; transfer or relocation of particular roles or services from one health care sector to another etc. Innovations have been funded through state investment, public-private partnerships and collaborations with non-governmental organisations and quasi-governmental organisations such as the World Bank (Krupp and Madhivanan, 2009).

Panchapakesan et al. (2009) speaks about the two components of service quality namely technical quality comprising of primary care attributes like treatment provided, infrastructure etc. and functional quality comprising of secondary care attributes or how the service is delivered like friendliness of service personnel, timely delivery etc. The important determinants of hospital service quality are infrastructure, personnel quality, and process of clinical care, administrative procedures, safety indicators, corporate image, social responsibility and trustworthiness of the hospital.
The study by Mayer (2009) indicates that Six Sigma has been widely used to improve quality of processes in healthcare systems. Six Sigma requires the completion of five phases of problem definition, measurement of critical factors for quality, analysis phase, improvement phase and control phase. It was found that the clinical process analysis using six sigma methodologies can significantly reduce defects and address quality issues.

There is a downward trend in the average efficiency of public hospitals. This, in turn, is related to a reduction in expenditure per hospital in the reform era. The situation needs urgent policy level alterations in a way that can lead to improvement in both efficiency and competitiveness of public health care services. This will take the fruits of globalization to the people below poverty line (Sengupta and Mondal, 2009).

Wilson (2009) discusses the impact of privatisation on the health care cost in Kerala. She opines that health care inequities has resulted not just due to the fact that most of the patients meet their health care expenses on their own but also due to the wider context of market-oriented and globalized health care.

A comparative analysis of National Sample Survey Organisations on select health parameters carried out by Husain and Ghosh (2010) showed that the share of the public institutions in treatment of hospitalized cases as well as non-hospitalized cases has shown a downward trend. With the increased financial outlay, the government sector should give better service so that the public at large will not come up with specific reasons like facilities being too far, dissatisfaction with medical treatment by doctor/facilities, long waiting period and required services not being available etc. Even in the case of non-hospitalised treatment, the burden on the household has been extremely high. The public sector has been catering to only about one-fifth of the non-hospitalized treatment, which has been more or less static over time.

A study by Burgers et al. (2010) showed that the patients with more chronic diseases reported less favourable experiences in terms of co-ordination of care. They also had lower level of satisfaction with overall quality of care. As chronic diseases are the leading cause of death in the world and their impact is growing, developing effective and efficient health care for patients with complex and multiple conditions is a national priority in many countries. Results indicate that more work is needed to improve coordination. Measures of coordination may be a helpful guide to those improvement programs and a useful tool for evaluating their effectiveness.
A study by Butt and de Run (2010) in the Malaysian private health care sector revealed that service gaps did exist in all major service dimensions. It was found that service users were mistrusted by their customers and they also opined that they never received the right service during the first time. Moreover, as customers usually come to a hospital with a stressed mental state, any delay in the provision of service will not be tolerated by the patients or their relatives. Hence to improve the service quality, training for hospital employees is very essential which will reduce delay in service delivery.

According to Rajagopal (2010), the critical factors that determine the preference of health care services by the poor are mainly cost of health care services and income of the patients. The poor people are favourable to utilize private health care services in Kerala. The public health care system has failed considerably in providing adequate health facilities to the poor people. On the other hand, private health care services could provide better facilities in terms of inpatient and outpatient care. A proactive role by private hospitals with support from the government and society can definitely create an ‘opportunity space’ for the poor who seek private medical help. An integrated system, which would work on a distributive and re-distributive mechanism would help vulnerable sections and bring them in the process of development.

Being a country with nearly 21 percent of global incidence of tuberculosis, India’s TB control initiatives will have global implications. Recent studies indicate that nearly 65 percent of households depend on private sector for meeting their health care needs. As such, private sector has a pivotal role to play in controlling TB. At the same time, we cannot neglect the role of public sector as well. As both the sectors have their own roles to play in controlling tuberculosis, the best solution would be to go for public-private partnerships, thereby, complementing each other rather than duplicating the investments and infrastructure. Hence, public-private partnerships should be resorted to wherever possible (Bhatia, 2010).

Kundu (2010) opines that rural Indian women are the most vulnerable section of population in terms of receiving health care services. In fact, the infrastructure necessary to provide proper care to women and children is lacking. In addition to this, various socio-economic factors also inhibits women from making use of the available facilities to the fullest. As such, despite the economic adversities, rural women are forced to depend on traditional health facilities.
Nana et al. (2010) in their paper aims to explore patients’ satisfaction with access to treatment in both the public and private healthcare sectors in London. The study showed that access is a major health consumption indicator in both the public and private healthcare sectors.

The paper by Desai and Wu (2010) discusses the major reasons for the sad state of maternal care in Indian households. It was found the factors affecting the extent of assisted delivery were manifold. Education, urbanization and first delivery positively influence the chance of assisted delivery. Caste and religion also seem to have a role in determining access to assisted delivery. Community infrastructural development also plays an important role in assisted delivery with women from urban areas receiving more care in comparison to their rural counterparts. Even non-health related factors like the kind of governance at health care institutions have a significant impact on assisted delivery.

The results of a project undertaken by Ramachandran, et al. (2010) in rural Odisha to assess the role played by Accredited Social Health Activists (ASHA) workers in creating awareness about maternal care among rural women indicted that the ASHAs were hardly able to perform their tasks effectively primarily due to lack of awareness and shortage of resources. The project team distributed video clips portraying the importance of proper maternal care to ASHA workers and provided proper training on how to use these videos to persuade the village women to go for better care. It was observed that gradually ASHAs developed a deeper understanding on how to use the video clips to persuade the rural women to access improved maternal care.

The study of private health service organisations in low and middle income countries indicated that many organisations have innovated across various areas ranging from marketing, finance, and operation. These included approaches such as social marketing, cross-subsidy, high-volume-low cost models, process reengineering etc. Rather than providing a wide range of services, these organisations had a narrow clinical focus, which enabled them to experiment with delivery processes. These private sector organisations reveal a range of innovations in health service delivery that have the potential to better serve the poor’s health needs that can be replicated (Bhattacharyya et al., 2010).

Vincent and Norman (2010) point out that innovation in healthcare industry is a complex issue and has got its own challenges. Though healthcare is rich in evidence based
innovations, they disseminate very slowly. Information technology will play a very vital role in healthcare innovation.

A comparative study of patient satisfaction at public and private hospitals in Romania by Laura et al. (2011) revealed that both in public as well as private hospitals there existed discrepancies in the expected and perceived service quality. The gap between the expected and perceived service quality was greater in the case of public hospitals than in private hospitals. The highest level of expectation was with regard to reliability followed by assurance. The highest level of discrepancy between expected and perceived quality was in case of the dimension with greatest level of expectation, i.e. reliability while the lowest level of discrepancy was in case of physical environment or tangible elements.

Ari et al. (2011) in their study found that nurses heavily influence patient care quality and safety. Most nurses held positive perspectives regarding service quality. An interesting finding is that demographic and socio-economic factors do not significantly influence nurses’ patient safety perceptions. Majority of nurses perceived patient safety as being good to excellent.

Daniel and Deirdre (2011) opined that patient satisfaction is significantly positively correlated with end-of-life patients’ propensity to return to a hospital. Other hospital characteristics also affect patient loyalty. Teaching and government hospitals have lower patient loyalty than their counterparts.

In a study at selected hospitals in Hyderabad, Ramanujam (2011) found that with increasing awareness about their rights, patients expect and demand high quality health care services. Rising literacy rate, higher levels of income and increasing awareness through deeper penetration of the media have not only contributed to the growth of health care sector in India but also for quality health care services. It is the professional excellence, personal touch in service, humanitarian approach and ethical values of the employees that play a significant role in the satisfaction of patients.

Ritu (2011) opines that the current public health care system in Uttar Pradesh is fraught with many problems that are perhaps making users lose faith in it. There are areas requiring urgent and immediate attention and suitable strategies have to be employed to improve the quality of health care services in public centres in order to make them more sensitive and responsible to the needs of the rural population. As the study was confined to
a single state with specific socio-cultural features generalizations for the entire nation have to be done with caution.

The study by Mehta (2011) to analyse the relation between service quality and patient satisfaction found that three factors namely promptness, medical aid and patient interest for service quality and amenities, clinical services and physical services were the main determinants of patient satisfaction with service quality. The study also showed that service quality and patient satisfaction were positively correlated.

Thomas and Rajesh (2011) found that decentralization improved the infrastructure facilities as well as equipment in the primary and secondary healthcare institutions and widened healthcare delivery. It succeeded in providing safe drinking water and sanitation facilities to the local public. The accountability of the public healthcare system was also enhanced. However, it could not address the issues of nutritional imbalance, old age care, lifestyle diseases and the changing morbidity pattern in the state.

D’Souza and Sequeira (2012) attempted to look at health care service quality from three different viewpoints namely doctor quality of care, nursing quality of care and operational quality of care and to assess the impact of them on patients’ satisfaction based on the data collected from a health care organisation in Karnataka. The results indicated that all these three elements were equally important in determining patients’ satisfaction and there was a particular need to improve the doctors’ quality of care at this hospital in order to enhance patient satisfaction.

Das (2012) opines that the government health infrastructure in India is very poor. These facilities are highly inadequate to meet the health care needs of the local public thereby increasing the health expenditure burden of common man. This has increased the incidence of contagious diseases like polio, tuberculosis etc. Hence, there is an urgent need to enhance the public health care mechanism throughout the country, especially in rural India.

Joshi (2012) opined that poverty and incidence of diseases are highly interlinked. A projection of 1.58 percent of GDP as public health expenditure is highly insufficient and unrealistic. With such meagre public spending on health, it may not be possible to attain the goal of ‘universal health’. As such there is an immediate need for increased commitment from government towards health care sector.
Rout (2012) stresses the need to have a proper system of health accounting wherein the
details of money spend by public as well as private sectors is maintained on a regular
basis. This is a well-accepted system for tracking system for tracking the sources and use
of funds in health sector. Though the country has already produced national health
accounts, certain crucial information relating to private health expenditure by trusts, NGOs
etc. were missing. However, a complete and comprehensive health account is very
essential as it forms the basis for the design, development, implementation and evaluation
of various health programs.

The decentralized health planning exercise in Bihar shows that it is possible to formulate
and implement decentralised health planning incorporating the specific needs and
priorities of the lower levels. This helps in developing district and block level health plans
which can also be monitored easily. This also provides certain amount of flexibility to
officials to re-allocate funds within major heads to suite the specific requirements of the
particular blocks and districts. So decentralised health planning has to be adopted to meet
the customised requirements of the local public (Singh et al., 2012).

The results of a study conducted by Senic and Marinkovic (2012) to identify the factors
impacting the satisfaction level of students at Serbia indicated that personal touch in
service provided, promptness and tangibility were the most prominent factors impacting
the satisfaction level of patients. This implies that doctors should devote more time to their
patients and show genuine interest in patients’ problems if they wish to improve the
overall satisfaction of patients with the services rendered.

To run satisfactory outpatient departments, it is important not only to reduce waiting
times, but also to ensure a good doctor-patient interaction process. It is essential that
doctors spend sufficient time with patients to communicate adequately about their illness,

A comparison of patients’ perception of service quality across public and private hospitals
by Mahapatra et al. (2013) showed that though the private sector had an edge over the
public sector, the service quality was not very different. The most important service
quality gap across sectors was that the medical facilities and equipments were not
maintained properly. Patients felt that the hospital environment was neither neat nor
comfortable and lacked proper directional signs. They also were of the opinion that
services were neither affordable nor accessible and were not available 24 hours. There was
no privacy during treatment and services were not provided promptly. Patients also felt that they were not treated with dignity and staffs were not courteous. The hospital authorities, both of public and private hospitals, have to take care of these aspects in order to improve patient satisfaction.

A study by Garrard and Narayan (2013) showed that patients had positive perception regarding staff politeness, patient respect and privacy. At the same time, there was scope for improvement in areas like hand cleanliness, women’s involvement in decision making and communicating risk. So there were both positive as well as negative perceptions of patients regarding the quality of services offered. The authorities concerned should take necessary steps to overcome the negative perceptions of patients and to sustain their positive perceptions.

A study on government health expenditure in India carried out by Varadarajan et al. (2013) revealed that absolute levels of total government spending on health, family welfare and child development are extremely low by international standards, not only in per capita terms but also as a share of GDP. This meant that a disproportionately large and growing proportion of the burden of health care is being borne by households in India. The central government accounts for nearly one-third of total government expenditure on health. In terms of GDP share, expenditure on health has been constant, although there has been a slight rise in spending under the budget head family welfare. The various state budgets indicate wide variations in the public spending by each state. Though direct correlation between government spending on health and health outcomes cannot be expected, the extent of government spending definitely had an implication on the broad indicators of health status like infant mortality rate, immunity levels, life expectancy etc. So beyond doubt, there is a link between public sector health spending and health status of the nation.

Gladwin et al. (2013) states that India falls in the bottom ranks among the 193 countries on various critical health parameters such as healthcare spending, health infrastructure and resources. Although rural areas account for nearly 70 percent of the Indian population, 80 percent of India’s doctors and 60 percent of hospitals are located in urban areas. A multi-pronged strategy involving various stakeholders is the need of the hour. Both public and private sectors need to work hand-in-hand to make healthcare available, accessible and affordable to all. Delivering affordable healthcare to India’s billion-plus people presents an enormous challenge, but at the same time, a great opportunity for the medical fraternity.
Pai and Chary (2013) stated that unlike other sectors, innovations penetrate very slowly into the health sector. Conceptualization and measurement of service quality in health care is very complex. Also, patients' perception of service quality greatly influences their choice of health care providers. Due to the negative perception of service quality, the extent of utilization of health care facilities has come down drastically. The poor perception about the quality of services rendered by public hospitals has induced more people to utilize private health facilities. It may be noted that attracting a new customers involves almost five times the cost of retaining an existing customer. Though measuring customer satisfaction is inevitable to retain the existing customers as well as to attract new customers, there is no standardised tool for measuring patient satisfaction, which makes comparison of satisfaction level of patients across hospitals as well as across sectors difficult. Hence, it is advisable to develop a universally acceptable scale for measuring patient satisfaction.

The results of a study by Abuosi and Atinga (2013) implied that patients' expectations were not met during treatment. Perceived service quality was below expectation on all service dimensions. The differences between perception and expectation in certain cases were found to be statistically significant. The health care managers have to undertake various measures like staff training to bridge the gap between the customer expectations and perceptions.

Till today, only few studies have been conducted in the developing countries to understand the types of relationship that existed between three key constructs — service quality, patient satisfaction and behavioural intentions. Most of the existing studies have been carried out in the developed countries and cannot be generalized in Indian context because constructs of service quality that have been developed in one cultural context may not be suitable for another. Therefore, more studies exploring the relationship between service quality, patient satisfaction and behavioural intentions within the health services in Indian context are necessary (Murti et al., 2013).
3.3 Research gap

The related review of previous studies analyses the role and the importance of the HRD and its functions in various sectors including the health care industry. These reviews also expose the implementation of the HRD practices and organisational outcomes on the one side. On the other side, the reviews cover the perception of the patient and bystanders on the health care quality at the hospitals. Health care human resource management has always been an area of interests to researchers the world over for decades. However, most of the research in this area was pursued in the western countries with relatively little work being done in the Asian and Indian context. This makes it very clear that health care human resource management has not been very successful in arousing the interest of Asian and Indian researchers. Moreover, the existing research works primarily focused on very specific and narrow HRD concepts and failed to bring out a broader perspective of health care human resource management issues. Work stress of health care professionals, work-life balance of nurses, nurse retention strategies, etc were few of the areas that attracted the attention of researchers. A closer look at the existing literature clearly shows that only very few studies were carried out in the health care sector in the state of Kerala, that too primarily in the private sector. Though the previous researchers have been able to bring out interesting facts relating to their areas of study, there exist a number of un-addressed issues in this area. There exist almost a complete vacuum of studies in the area of HRD practices/climate at government hospitals in Kerala. However, a holistic understanding of HRD practices/climate existing at government hospitals is very essential for improving employee performance and patient care quality at government hospitals. Hence the present study makes an attempt to fill this vacuum by looking at HRD practices at government hospitals, as a holistic concept encompassing various elements like manpower planning, performance management, training and development, compensation management etc, as perceived by the doctors working at these hospitals. The study also tries to develop an understanding about the perception of patients and bystanders regarding the quality of services offered at these hospitals.