CHAPTER I
INTRODUCTION

1.1 Background of the study

The present day world is characterised by stiff competition in all sectors. There are innumerable organisations providing similar products and services. All these institutions compete to lure the same pool of customers who are at liberty to exercise their choice. All establishments make their best possible effort to retain their existing customers and to attract the customers currently loyal to their competitors. The key to attracting maximum customers is to provide best quality products and services to the customers at the lowest possible cost, thus giving them maximum satisfaction. This is possible only if the firm makes judicious use of its resources. In any concern, it is the employees or the human resources who make use of all available resources to bring out products or provide services to customers. Though the quality of material inputs plays a major role in determining the quality of output, it is the efficiency with which these resources are used by the employees that makes a huge difference. Even the nature of services offered by the salesmen at the point of sale influences the customers’ purchase intentions. For example, if salesmen at a particular super market are perceived to be customer friendly, the buyers usually tend to revisit the same store. Hence, it is clear that even while purchasing a standardised branded product, the human element plays a significant role. In the case of services which is more customised and intangible in nature, the role of human resources is even more significant. Generally, customers form an impression about the quality of services offered based on the quality of service interactions with service providers. In case of health care, which is highly service oriented, the attitude of caregivers, i.e. the doctors, nurses and support staff have a major say in the perception of patients and bystanders regarding the quality of services offered at the hospitals. The behaviour and attitude of doctors greatly influence the satisfaction level of patients. Among others, one of the important factors that impact the attitude and behaviour of doctors is their perception regarding the Human Resource Development (HRD) climate existing at hospitals. A positive impression in the minds of doctors regarding the HRD climate may positively influence patient care quality and vice-versa, which may in turn influence patient satisfaction. In order to remain competitive in today’s world, it is very important for the organisation to make judicious use of the finite resources at its disposal. Among all the
resources, since human resources are the only ‘live’ resource, the way in which all other resources are utilized depends on the nature and attitude of its human resources. So it is very important for an organisation to ensure that employees are happy with the organisation and that they feel motivated and committed enough to be its employees. The satisfaction and motivation of employees depends on various aspects like the work environment, kind of rewards and recognition they receive, training facilities, career development opportunities etc. provided by an organisation. In short, we can say that the HRD practices at an organisation are a prime factor that influences the satisfaction level of employees. Especially in the case of service organisations like hospitals which are people oriented, the need to maintain employee satisfaction and commitment is very important. Therefore, it is very important for hospitals to understand employees’ perception about the HRD practices existing there. Similarly for any organisation to be successful in the long run, it has to ensure that its customers are satisfied to the fullest. It is important for any organisation to understand customers’ perception regarding the kind of products or services it offers. The case of hospitals is not different. Hence, the present study aims to examine the perception of doctors regarding the Human Resource Development (HRD) practices as well as the perception of patients and bystanders regarding the quality of patient care provided at government hospitals in Kerala.

1.2 Human Resource Development (HRD) – An introduction

Land, labour, capital and organisation are the basic resources necessary for any organisation to function. The efficiency of any organisation depends on how well these resources are used. It is the people or human resources working in an organisation that make use of all other resources in order to attain the organisational goals and objectives. So the ability of the human resources in making judicious use of the finite resources of the organisation is a prime factor determining the success of the organisation. Therefore, in a way, it is the quality of human resources of an organisation that determines its ability to successfully survive in this competitive era. In this situation, the development of human resources has assumed greater significance as a mechanism to understand and meet ever changing requirements to perform their job effectively and efficiently, eventually leading to customer satisfaction and economically viable units. In other words, Human Resource Development is not being considered as an end in itself but is being practised as a dynamic and creative means to achieve increased productivity and profitability, improved morale and career development of employees, better industrial relations etc. with an end to
achieving the overall goals of an organisation. Every business and industrial unit has realised this and, in one form or the other has, today, started the process of Human Resource Development. The awareness about Human Resource Development is more wide-spread among mega-sized organisations working at national and global levels. Various innovative measures are being adopted and a good amount of expenditure is also being incurred by them on Human Resource Development. Of late, the Government of India has realised the importance of Human Resource Development and has set up a separate Ministry of Human Resource Development (Agrawal, 2005).

According to Rao (2006), the scope of Human Resource Development is extended, on the one side, to developing competencies of human resource by enhancing knowledge, building skills, changing attitude and teaching values and on the other, to the creation of favourable conditions through public policies, programs and other interventions to help people apply these competencies for their own and others' benefits and making things happen. Human Resource Development is the process of increasing the knowledge, skills, and the capacities of all the people in a society. In economic terms, it could be described as the accumulation of human capital and its effective investment in the development of an economy. In political terms, Human Resource Development prepares people for adult participation in the political process, particularly as citizens in a democracy. From the social and cultural points of view, the development of human resources helps people to lead fuller and richer lives, less bound to tradition. In short, the process of Human Resource Development unlocks the door to modernisation.

The new focus of organisations on strengthening the knowledge and skill base of its employees has brought about drastic change in the role of their human resources development. Organisations, especially those with a learning culture, are realising the importance of knowledge, especially tacit knowledge and are now making all possible efforts to capture and preserve it. Human Resource Development initiatives provide opportunities for employees to learn new skills as well as to sharpen their existing skills. Focus on strategic Human Resource Development has been emphasised as a key contributor in ensuring organisational effectiveness and maximising return from their most important asset, the people in the organisation. It has been argued that effective management and innovative approaches to the development of employees will enable organisations to capture and embed knowledge and skills. Organisations that are seeking not just to survive, but to maximise operational effectiveness in an ever-changing
environment, need to ensure that at all levels, the Human Resource Development strategy is aligned with broader strategic imperatives, and that sufficient emphasis is placed on the Human Resource Development function. It is the role of management to ensure that the organisation and its people acquire the competencies and knowledge they need through education, training and development activities.

Sustaining a competitive advantage increases the probability of long-term survival and financial success of an organisation (Kuratko, Ireland, and Hornsby, 2001). It has been argued that in the knowledge era, the effective involvement, management and development of staff can lead to this competitive advantage. In fact, the most strategic way to invest in people is through learning activities. Carneiro (2001) argues that an organisation’s capacity to exploit its knowledge and learning capabilities should be one of its competitive strategies. Cullen (1999) further highlights the significance of both individual and organisational learning in order to develop organisational capacities. Boer et al. (2001) presents learning aspects similar to Cullen (1999), but they believe organisational capacities enable learning behaviours to develop across the organisation. So to remain competitive, firms seeking to improve their position and processes must sustain a high level of learning that both refines current practices and capabilities and develops new ones. Human Resource Development has evolved as a critical element of broader business and human resource management strategies. The importance of an appropriately skilled and developed workforce is recognised by many organisations as essential to the implementation of continuous improvement programs.

Mahajan and Virmani (1988) concluded that strong human resource is a sine qua non for the success of the public sector. Prasad and Bannerjee (1981) also concluded that competent human resources are the need of the hour for public enterprises. Jain (1996) conducted a research on Human Resource Development practices in Indian industries with specific reference to BHEL and NFL and highlighted the scope of Human Resource Development for unleashing employee potential. Research on Human Resource Development in public enterprises like NTPC, State Electricity Boards and other state level enterprises covered all pertinent aspects of Human Resource Development and, by and large, these studies revealed the importance of Human Resource Development. These studies maintain that it is a complete path starting from industrial relations to Human Resource Development.
Public hospitals are usually the major providers of health care in most developing countries. Like any other public organisation, they are susceptible to the inefficiency of the bureaucratic system. Inadequate funding resulting in low quality services is another major problem. Apart from the inequity in health care accessibility due to restrictive user fees, Human Resources Development is another important area of concern for most health reform movements. The current concerns in relation to public hospital reform mainly focuses on management issues, particularly the employment status of hospital civil servants. These include the issues of salary scale, career path, continuing education/training, fringe benefits and pension system etc. Little attention is paid to the long term implications of human resources planning on production and distribution. Long term implications on Human Resource Development from public hospital reform should be closely monitored and evaluated together with other issues such as financial sustainability, quality of services, efficiency and equity (Wibulpolprasert, 1999).

1.3 Health care

Health the most important kind of wealth one can possess; the physical, mental and social health of the entire population is a nation’s fundamental natural resource. If health becomes only the province of the wealthy, that nation has an ominous future. Health is the essential foundation that supports and nurtures growth, learning, personal well-being, social fulfillment, enrichment of others, economic production and constructive citizenship. We should keep in mind that successfully promoting good health has intrinsic value.

With the world’s national economies facing transition from producing natural resources to adding value to resources through manufacturing, and now to the rise of service economy and information management, the allocations for developing national infrastructures will increasingly shift to investing in human infrastructure. Only by improving the health and learning opportunities of the next generation can, human resources, can the most valuable infrastructure for a nation’s future be solidly built (David, 2003).

Health is a major determinant of happiness. Health is often equated with ‘absence of disease’. World Health Organisation has defined health most broadly ever since its establishment in 1964. “Health is a state of complete physical, mental and social well-being and not merely the absence of illness or infirmity”. Later, it was amplified to include “socially and economically productive life”. Health has several dimensions, each of which
is important. The relative importance of each dimension with respect to the other depends on the circumstances in which an individual or community functions (Misra, 2007).

There are a wide variety of health care systems around the world with as many histories and organisational structures as there are nations. In some countries, health care system planning is distributed among market participants. In others, there is a concerted effort among governments, trade unions, charities, religious, or other co-ordinated bodies etc. to deliver planned health care services targeted to the populations they serve. However, health care planning has been described as often evolutionary rather than revolutionary. The goals for health systems, according to the World Health Organisation, are good health, responsiveness to the expectations of the population, and fair financial contribution. Progress towards them depends on how systems carry out four vital functions: provision of health care services, resource generation, financing, and stewardship. Other dimensions for the evaluation of health care systems include quality, efficiency, acceptability, and equity. They have also been described in the United States as "the five C's" - Cost, Coverage, Consistency, Complexity and Chronic Illness. Also, continuity of health care is a major goal. The management of any health care system is typically directed through a set of policies and plans adopted by government, private sector business and other groups in areas such as personal health care delivery and financing, pharmaceuticals, health human resources, and public health. Direct comparisons of health statistics across nations are complex. The Commonwealth Fund, in its annual survey, "Mirror, Mirror on the Wall", compares the performance of the health care systems in Australia, New Zealand, the United Kingdom, Germany, Canada and the U.S. Another study conducted by The Commonwealth Fund in 2007 found that, although the U.S. system is the most expensive, it consistently underperforms compared to the other countries. A major difference between the U.S. and the other countries according to the study is that the U.S. is the only country without universal health care.

1.4 Health care quality

Quality in health and medical care has two dimensions: one is objective and technical; the other is subjective and qualitative. However exciting the technological advancement in medical science may be over the past few years, the patients' experience of illness and medical care is at the heart of clinical medicine which is aimed at relieving human suffering. Suffering, as practicing clinicians define, is a subjective experience that may or
may not respond to therapeutic procedures directed towards the pathological processes of
disease, even when those regimens are technically effective (Cassell, 1982).

What patients experience, and what they think of that experience, should also matter to
health care planners, policy makers, and managers, because that experience, as much as
the technical quality of care, will determine how people use the health care system and
how they benefit from it. The patient centered approach is widely advocated, but
implementation in practice is limited and is related to characteristics of both doctors and
patients. Some aspects of patient centeredness may have important benefits for patients
like improved communication can improve satisfaction and biomedical outcomes,
Involving patients in partnership can have benefits without increasing their anxiety and
with the potential to reduce adverse outcomes connected to prescribing (Little et al.,
2001). In the broadest terms, patient-centered care is care organised around the patient. It
is a model in which providers’ partner with patients and families to identify and satisfy the
full range of patient needs and preferences. Not to be overlooked in defining patient-
centered care is its concurrent focus on staff. To succeed, a patient-centered approach must
also address the experience of staff as their ability and inclination to effectively providing
care for patients is unquestionably compromised if they do not feel cared for themselves.

Although patients may not always be able to accurately evaluate the clinical quality of
care or whether safety measures are in place, patient safety and high clinical quality are
fundamental to a patient-centered approach. The patient-centered care does not replace
excellent medicine. They complement each other.

The significance of the well-recognised health care “quality chasm” has been
acknowledged by a broad array of stakeholders, who have responded with efforts to
identify, understand, and correct specific shortcomings in health care delivery (Mittman,
2004).

Over recent decades, the health care system has experienced some movement from a
paternalistic medical model to one that engages the patient in decision making and self-
care. It reflects the beginning of a shift from a professionally driven system toward one
that is “patient centered” or “consumer centered” recognizing and incorporating an
individual patient’s perspectives (Laine and Davidoff, 1996).
The assessment of quality must rest on a conceptual and operational definition of what the “quality of medical care” means. Many problems are present at this fundamental level, for the quality of care is a remarkably difficult notion to define. The outcome of medical care, in terms of recovery, restoration of function and of survival, has been frequently used as an indicator of the quality of medical care. Many advantages are gained by using outcome as the criterion of quality in medical care. The validity of outcome as a dimension of quality is seldom questioned. However, a number of considerations limit the use of outcomes as measures of the quality of care. The first of these is whether the outcome of care is, in fact, the relevant measure. This is because outcomes reflect both the power of medical science to achieve certain results under any given set of conditions and the degree to which “scientific medicine,” as currently conceived, has been applied in the instances under study. Even in situations where outcomes are relevant, and the relevant outcome has been chosen as a criterion, limitations must be reckoned with many factors other than medical care that may influence outcome, and precautions must be taken to hold all significant factors other than medical care constant if valid conclusions are to be drawn. Although some outcomes are generally unmistakable and easy to measure, other outcomes, not so clearly defined, can be difficult to measure. All these limitations to the use of outcomes as criteria of medical care are presented not to demonstrate that outcomes are inappropriate indicators of quality but to emphasise that they must be used with discrimination. Outcomes, by and large, remain the ultimate proof of the effectiveness and quality of medical care.

Another approach to quality assessment is to study not the process of care itself, but the settings in which it takes place and the instrumentalities of it, which is the product. This may be roughly designated as the assessment of structure, although it may include administrative and related processes that support and direct the provision of care. It is concerned with such things as the adequacy of facilities and equipment, the qualifications of medical staff and their organisation, the administrative structure and operations of programs and institutions providing care, fiscal organisation and the like. The assumption is made that given the proper settings and instrumentalities, good medical care will follow. This approach offers the advantage of dealing, at least in part, with fairly concrete and accessible information. It has the major limitation that the relationship between structure and process or structure and outcome, is often not well established.
Since a multidimensional assessment of medical care is a costly and laborious task, the search continues for discrete, readily measurable data that can provide information about the quality of medical care. The data used may be about aspects of structure, process or outcome. The chief requirement is that they be easily, sometimes routinely, measurable and be reasonably valid (Donabedian, 2005).

Quality measurement and management is one of the most important topics in all services, including health care, nowadays. There are many structured and unstructured efforts to measure various components of quality. However, health care system still lacks a unified process for assessing the various elements of quality. It is not surprising, knowing the complexity of health care services and difficulty of service quality evaluation.

Healthcare service quality is defined differently by the patients, service providers and various other parties involved in the healthcare delivery system. The most commonly accepted definition of health care quality was proposed by Institute of Medicine, United States of America (IOM) in 1990, where quality of care was defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. To some extent, quality is in the eye of the beholder. That is the reason why expectations associated with different aspects of care are likely to vary among different stakeholders.

Patients tend to define quality in terms of their preferences and values, and that leads to quality definition emphasising satisfaction with health care and the results such as recovery, mortality and functional status. An interest in the views of patients is not fundamentally inconsistent with physicians’ views of quality. When talking about the quality of personal interaction between the service provider and the client, health care professionals have always acknowledged that satisfying patients is essential to ensure high quality care. However, at the same time, physicians have often discounted the importance of patients’ perspectives stating that the patients have very limited knowledge of what constitutes technical quality and because of the difficulty of measuring patients’ views accurately and reliably. Patients tend to evaluate health care quality according to the responsiveness to their specific needs. Most patients define quality as efforts of physicians to do everything possible for a patient. They often focus on effectiveness, accessibility, interpersonal relations, continuity and tangibles as the most important dimensions of quality.
Health care professionals tend to define quality in terms of the attributes and results of care, and this definition emphasises the technical excellence with which care is provided and the characteristics of interactions between provider and patient. Technical quality of health care has two dimensions: i) the appropriateness of the service provided and ii) the skills with which appropriate care is provided. High technical quality consists of doing the right thing right. To do the right thing requires physicians to take the right decision about care for each patient. Physicians also tend to balance between efforts to control costs, their own judgments about best ways of treatment and demand to consider the values of patients while making treatment choices (McGlynn, 1997). Traditionally, healthcare providers, while talking about quality focused on the technical nature of the healthcare events. The focus has been on the training and updated skills of the physicians and the nature of actual medical outcome. From the provider’s perspective, quality care implies that he or she has the skills, resources and conditions necessary for improving the health status of the patients according to current technical standards and available resources.

Managers of healthcare organisations are rarely involved in delivering patient care, although the quality of patient care is central to everything that they do (Piligrimiene and Buciuniene, 2008). Focusing on various dimensions of quality can help to set administrative priorities. Healthcare managers must provide for the needs and demands of both providers and patients. Also they must be responsible stewards of the resources entrusted to them by government, private entities and the community at large. Hence, the healthcare service quality evaluation must find a way, which encompasses expectations and needs of every party involved.

Improvement in the quality of primary healthcare services apart from increasing accessibility and affordability has become a matter of grave concern for the developing nations in the recent years. However, the meaning of quality in healthcare system has been interpreted differently by different researchers. Ovretveit (1992) identified three “stakeholder” components of quality: client, professional, and managerial. From the client’s viewpoint, it is the meeting of the patient’s unique need and want (Atkins et al., 1996) at the lowest cost (Ovretveit, 1992), provided with courtesy and on time (Brown et al., 1998) while professional quality involves carrying out of techniques and procedures essential to meet the client’s requirement and managerial quality entails optimum and efficient utilization of resources to achieve the objectives defined by higher authorities. According to the Institute of Medicine (2001), quality in healthcare is, “the degree to
which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” Meeting the objectives of both physicians and patients has been equated with the concept of quality in healthcare by some researchers (Morgan and Murgatroyd, 1994) while others have focused on user perception, technical standards, and provision of care (Boller et al., 2003; Hulton et al., 2000). Quality of care comprises of structure, process, and health outcomes (Peabody et al., 1999); and there are eight dimensions of healthcare service delivery: effectiveness, efficiency, technical competence, interpersonal relations, access to service, safety, continuity, and physical aspects of healthcare (Brown et al., 1998). The concept of quality is multifaceted connoting different meanings to different stakeholders such as government, service provider, hospital administrators and patients (Sharma and Narang, 2011).

1.5 Patient centered care

For any service, it is important to satisfy the needs of its customers to the fullest since dissatisfied customers lead to revenue loss thereby posing a threat to its long term sustainability. This is true in the case of hospitals also. But publicly funded health care does not face the grim prospect of collapse due to the loss of customers. It can and does keep the customers it fails to satisfy because they have no other place to go. Most of these failures are due to disrespect, inconvenience, poor communication and fragmentation. The basic reason for this is that the system is designed for the providers rather than for the users of the service.

Originally coined by Balint in 1969 to express the belief that each patient has to be understood as a unique human being, patient-centered medicine began as a descriptive account of how physicians should interact and communicate with patients.

Summarising patient centeredness most succinctly, Mc Whinney, (1989) has described the patient-centered approach as one where the “physician tries to enter the patient’s world to see the illness through the patient’s eyes.” This notion of “seeing through the patient’s eyes” has become perhaps the most concise description of patient centeredness, and has led to several outgrowths of the early patient-centred movement. It may have been clearer, by sincerely looking through the patient’s eyes, that there is a great deal more to fix in the healthcare system than the interaction style of its practitioners. Seven dimensions of patient-centered care were identified: 1) respect for patients’ values, preferences and
expressed needs; 2) coordination and integration of care; 3) information, communication and education; 4) physical comfort; 5) emotional support and alleviation of fear and anxiety; 6) involvement of friends and family; and 7) transition and continuity. (Edgman-Levitan, Daley and Delbanco, 1993).

The patient-centered care should integrate patient preferences, needs and wants, engage patients in clinical decision making and tailor the treatment to maximise outcomes in a cost effective way. This relatively old concept provides unique challenges and opportunities for its application to the ever changing healthcare arena. Such decision making demands integration of best medical knowledge into patient care, supporting more active patient participation in care and promoting systems of care that are responsive to the patient’s needs or preferences. Thus, patient-centered care model integrates (1) understanding the patient and the illness, (2) arriving at mutual understanding of illness management and therapeutic alliance, (3) providing valued information, (4) enhancing hospital, doctor and patient relationship; and (5) sensitivity about resource allocation and cost (Jayadevappa and Chhatre, 2011).

1.6 Health care scenario in Kerala: An overview

Kerala has a long history of organised health care. When the state was formed in 1956, the foundation for a health care system accessible to all citizens were laid. The wide prevalence of Ayurveda as well as other traditional forms of medicines along with the early introduction of western system of medicine has paved the way for the development of health care system in Kerala. Besides the existence of Ayurveda and other forms of traditional medicines, the colonial powers introduced the western system of medicine in Travancore, a part of Kerala as early as 1811. The first hospital in Kerala became operational in 1817. This marked the beginning of a revolutionary change in the history of health care development in Kerala. Thereafter, a series of government hospitals were established across Kerala. The promotion of education and health care was considered a priority by the different governments that ruled the state, irrespective of political inclination.

1.6.1 The Kerala model of health care

The hallmarks of the Kerala model in health are its low mortality rates, high life expectancy, low cost of health care and its universal availability. The state is often
described as a land of ‘good health at low cost’ and is reported to have the lowest rural-urban inequalities in public health status. Kerala’s low fertility rate which is below replacement level has helped to improve the health of mother and child by limiting the mother’s responsibilities as mother to a few children and by limiting the pregnancy/delivery/post delivery problems to a few pregnancies. Maternal mortality rate in Kerala is relatively low. Kerala’s remarkable achievements in health are almost comparable to that of developed countries. There are many socio-economic conditions unique to Kerala, which have made this health model possible. Similarly, Kerala’s much acclaimed outcomes in health care were to a large extent based on its vast network of public health institutions with the sub-centre and Primary Health Centers, Community Health Centers, Taluk / District Hospitals and Medical College Hospitals at the primary, secondary and tertiary levels. Apart from modern medicine, ayurveda, homeopathy, and other alternative systems are also very popular in Kerala. The state has a highly literate population compared to other Indian states. This, and especially high female literacy has to be given due credit when we look for the reasons. One of the factors for the better health status of Kerala is its better living conditions. The state has been able to reduce the infant mortality, child mortality, peri-natal and neonatal mortality and maternity mortality substantially. The sustained efforts of the government, both before and after independence, along with high literacy rate, especially female literacy rate, were the major correlates of this achievement. However, the widely acclaimed Kerala Model of Health has started showing some disturbing trends recently (Nitya, 2013).

Life expectancy in Kerala is about 74 years of age, while in states like Bihar, Assam, Madhya Pradesh and Uttar Pradesh, a person is expected to live up to 60 years of age. Among the four southern states, Kerala has already achieved the goal of a Maternal Mortality Rate (MMR) of 100 per lakh live births, but within the group, Karnataka lags significantly behind with an MMR of 178 per lakh live births.

Utter Pradesh recorded the highest Crude Birth Rate (CBR) of 28.3 per 1000 populations and Goa the lowest rate of 13.2 per 1000 population. Kerala (14.8 per 1000 population) among the bigger states and Goa (13.2 per 1000 population) among the smaller states and union territories recorded the lowest CBR during 2010. The Infant Mortality Rate (IMR) varied very widely across the states. Kerala, with an IMR of 13 is the best performing state among bigger states in the country. The highest Child Mortality Rate was recorded in
Madhya Pradesh closely followed by Uttar Pradesh, Assam and Odisha. Kerala with 2.9 CMR is the best performing state (Economic Review, 2012).

1.6.2 Public health infrastructure in Kerala

The entire network of public health care services is under the control of Directorate of Health Services. Out of the 1255 institutions under DHS, 67 percent are Primary Health Centers, 18 percent are Community Health Centers, 9 percent are Taluk Head Quarters Hospitals/District Hospitals/General Hospitals, 2 percent are Specialty Hospitals and 4 percent are other hospitals.

During the first year of the XIth Plan, there were 1274 health care institutions with a bed strength of 36642. During 2012, the number has fallen to 1255 and bed strength has increased to 37388. During the XIth plan period, 18 leprosy sanitariums and a TB centre was merged with general health system. Hence, it is evident that there is a shortage of 19 institutions under the Directorate of Health Services during the period. At the same time, there is a considerable increase in the bed strength of the institutions. Due to the up-gradation of PHCs into CHCs there has been a fall in the number of PHCs in the state during 2012. Similarly dispensaries were also up-graded into CHCs. These institutions possess huge infrastructural facilities but may not have qualified medical and paramedical personnel.

The present public health infrastructure under allopathic system of medicine comprises of 1255 institutions consisting of 11 General Hospitals, 15 District Hospitals, 660 Primary Health Centers, 230 Community Health Centers, 19 Specialty Hospitals, 17 T.B Clinics/Centers, 80 Taluk Hospitals, 175 24 x 7 Primary Health Centers and 48 Other Hospitals. The details of these institutions are given in Table 1.5 below (Economic Review, 2012).

1.6.3 HRD at government hospitals

Human Resource Development has been defined by Saiyadain (1991) as a process undertaken to promote the intellectual, psychological, cultural, social and economic development of the person. As human beings, we always look forward to learn new things in life. As such, employees have a continuing interest to update their knowledge and skill set to protect them from becoming obsolete. Employees, irrespective of their knowledge, experience, industry etc, always remain very eager to learn new skills so that they can
move up their career ladder. It is through Human Resource Development activities that this unending desire of employees, to acquire new knowledge and skill set, is addressed. In order to retain and motivate employees, organisations have to provide growth opportunities to them by undertaking various HRD activities. This is true in case of government hospitals as well. However, as HRD initiatives call for considerably huge investment in terms of money and time, it is very important that the HRD interventions yield the expected results. As noted by various scholars like Sambrook (2001), Walton (2003), Lee (2001) etc. there are various antecedents that should be present in any organisation that enable effective implementation of HRD practices. Among others, some of the most important aspects that facilitate successful implementation of Human Resource Development activities include openness, effective communication, blame-free culture etc. There should also be a learning and research culture that motivates learning, risk-taking and change and focuses on trusted long-lasting relationships. Moreover, there are certain additional attributes like initiative, innovation, creativity, enthusiasm, and experience of staff members that influence the success of HRD at government hospitals. It was observed that most of these aspects were missing at government hospitals in Kerala thereby hindering the effectiveness of HRD. However, it may be noted that even in the absence of antecedents, some of the traditional fundamental HRD practices like training programs, periodic revision of compensation package, performance appraisal in the form of confidential reports, seniority based promotions, teamwork, though not very effective, were present at government hospitals. In addition to the absence of antecedents, unfavorable government policies, traditional incentive and promotional schemes, negative attitude of trade unions, workload of employees as well as inadequate career growth opportunities are the underlying causes for the limited success of Human Resource Development interventions at government hospitals in Kerala. Hence, the authorities concerned should make all possible efforts to create a positive Human Resource Development climate by overcoming all the constraining factors thereby improving the quality of patient care services.

1.6.4 Private health sector in Kerala

Private sector is playing a vital role in provisioning the healthcare services in Kerala. Studies indicate that there are both positive and negative aspects of private health services. The positive features observed are that persons belonging to all quintiles consume this sector's services and that duration of treatment is lesser in this sector. However,
government hospitals are preferred over private hospitals for treatment of diseases like cancer and other tumors as the associated costs are prohibitive. While new hospitals are coming up day by day on one side, many of the existing hospitals simultaneously close down. This underlines the uncertainty associated with private sector provisioning of health care services. The demand for large private sector hospitals is expected to be a temporary phenomenon and demand for small hospitals and nursing homes is expected to be a more permanent phenomenon. Utilization of inpatient treatment facilities at private hospitals is as frequent among poor as among the rich. However the deprived social groups are increasingly getting alienated from the private hospitals. Another notable observation is that the ‘out of pocket’ expenditure on hospitalization as a percent of household consumer expenditure has increased. It is confirmed that while private sector is indeed providing a significant proportion of in-patient care to the poor, it taxes them severely. Also the overwhelming dominance of the private sector across time has resulted in marginalised groups getting more and more restricted access. If this continues for a while, there can be situations where the socially marginalised are less likely to avail health care when needed; and when compelled to opt for health care they also might opt for private facilities; and this utilization taxes them severely (Dilip, 2008).

Since Kerala has made many achievements in terms of conventional parameters, it is time to raise the bar and aspire towards higher levels of quality and efficiency. Ensuring quality in every interaction with patients, being transparent, avoiding medical errors, avoiding systemic pitfalls such as hospital acquired infections and medical errors are some of the target the health sector in the state should aspire to. This would mean evolving statements of standards to be maintained, building capacity of service to comply with them, monitoring that they are adhered to and taking corrective measures when they are not. Improving efficiency to ensure better results and managerial efficiency to prevent bottlenecks, giving autonomy for hospital management are also needed. Technical support for these reforms may not be available in state. Kerala will try to get such technical support from wherever needed but will try to build such capacity in one of the institutions in the state with external support. Wherever possible attempt will be made to put in place a certification program for one of the academic institutions so that technical capacity is institutionalized (Department of Health and Family Welfare, 2013).
1.7 Significance and scope of the study

An organisation is defined as a group of people working together for a common purpose. So the very definition of an organisation itself stresses the role of people. Among all the factors that make up an organisation, human resources are the only factor that is live, while all others are merely physical in nature. It is the people or human resources who make use of all other resources to meet their goals. So the success of any organisation be it in the manufacturing or service industry, depends on how effectively the people or employees of an organisation make use of the rest of the resources. So in short we can say that for an organisation to be successful its employees should be performing at their best. This is more so in case of hospitals because health care is a people oriented activity that requires joint and co-ordinated efforts on part of care-givers and care-receivers. The performance of employees is directly co-related to their motivation and commitment to an organisation. One of the primary factors that determine the commitment and motivation of employees is the kind of HRD climate perceived to be existing at hospitals. The motivation and commitment of employees directly impacts the quality of services offered at these which in turn determines patient satisfaction. So the perception of doctors, who are an integral part of patient care process, about the HRD climate at hospitals can have serious implications on the quality of care and patient satisfaction. Similarly, a patient usually comes to a hospital, expecting a certain quality of service. Once the patient receives the service, he/she compares the perceived service quality with the expected service quality. Any gap between the expected and perceived service quality leads to dissatisfaction of patients. Moreover, generally a patient is accompanied by bystanders whenever they come to a hospital. As patients will be in an ill state, many a times, rather than patients it is the bystanders who decide about the quality of care provided at a particular hospital. It is the bystanders who even decide about which hospital the patients should be taken to in cases where they are not in a position to take a decision. So, the perception of patients and bystanders regarding the quality of care has a very crucial role in determining the loyalty of patients. Hence, the present study makes an attempt to understand the perception of doctors regarding the extent of HRD practices and the perception of patients and bystanders regarding the quality of care provided at government hospitals in Kerala.

Public health institutions include all institutions providing health services under different systems of medicines like the general hospitals, district hospitals, taluk head quarters
hospitals, women and children hospitals, government hospitals, primary and community
health centers, child health centers, ayurvedic hospitals and dispensaries, homeopathic
dispensaries and hospitals etc which are funded by the government. As per available
statistics, there are nearly 1760 public health care institutions across Kerala. As such, it
will not be practically possible to include all the institutions and complete the study within
the limited time frame. Considering this reality, the scope of the present study is limited to
26 government hospitals consisting of 15 district hospitals which already existed as well as
10 general hospitals and 1 specialty hospital which were later raised to the status of district
hospitals.

1.8 Rationale behind the study

In the healthcare industry, quality of care is more than a concept. To begin this discussion,
we must have a shared definition of quality and understand the strengths, weaknesses, and
misconceptions of commonly held concepts about quality in healthcare. The most durable
and widely cited definition of healthcare quality was formulated by the Institute of
Medicine (IOM) in 1990. According to the IOM, quality consists of the “degree to which
health services for individuals and populations increase the likelihood of desired health
outcomes and are consistent with current professional knowledge” (Lohr, 1991). The
public has become more aware of the role of quality of care in healthcare. The definition
has not changed, but the public and the industry’s awareness certainly has. High-profile
patient safety failures have had a profound impact on the evolution of the public’s
awareness of quality of care.

In response to the realization of patient care failures, various agencies including World
Health Organisation and Institute of Medicine have made various recommendations for
improving patient care quality and safety. These recommendations focused on providing
safe, effective, patient-centered, timely, efficient and equitable care. Though hospitals and
health care professionals have been following some of these recommendations, there is
still a long way to go in terms of improving the quality of care. There are numerous factors
responsible for the very limited implementation of quality and safety improvement
measures like technical challenges in distinguishing quality across physicians and other
healthcare providers, the unwillingness of hospitals, patients, and physicians to use the
information derived from quality management etc.
Provision of quality care requires a joint effort on part of all stakeholders involved in patient care process. The core responsibilities of health-service providers for quality improvement are numerous. Providers may be seen as whole organisations, teams, or individual health workers. In each case, they will ideally be committed to the broad aims of quality policy for the whole system, but their main concern will be to ensure that the services they provide are of the highest possible standard and meet the needs of individual service users, their families and communities. Improved quality outcomes are not, however, delivered by health-service providers alone. Communities and service users are the co-producers of health care services. They have critical roles and responsibilities in identifying their own needs and preferences, and in managing their own health with appropriate support from health-service providers.

While it is important to recognise these differences in roles and responsibilities, it is equally important to recognise the connections between them. Decision-makers cannot hope to develop and implement new strategies for quality without properly engaging health-service providers, communities and service users. Health-service providers need to operate within an appropriate policy environment for quality and with a proper understanding of the needs and expectations of those they serve, in order to deliver the best results. Communities and service users need to influence both quality policy and the way in which health services are provided to them, if they are to improve their own health outcomes.

With a high level of demand for health care services and a relatively short supply of health care professionals, there is a burden on health care administrators to provide consistently high levels of care while maintaining efficiency, at low cost. Although some improvements in quality of care can be achieved through advancement in technology and infrastructure, most dramatic improvements can be achieved through people. Previous studies have shown that unsatisfied health care employees negatively affect the quality of care which in turn affects the loyalty of patients towards a hospital (Peltier, Dahl and Mulhern, 2009). Employee satisfaction and retention plays a crucial part in the success of a hospital. Simply providing great clinical care will no longer win the hospital accolades in the eyes of the patients simply because they expect it. An increased focus from the quality assurance and human resources department of the hospital is needed to analyse employee satisfaction. Studies have shown a direct correlation between employee satisfaction and patient satisfaction. A survey conducted by the American Psychology Association
indicated that half of the employees who said that they do not feel valued at work intend to look for a new job in the next year. In addition, the survey also indicated that 93 percent of employees who reported feeling valued said that they were motivated to do their best at work and 88 percent reported feeling more engaged in the workplace (Pund and Sklar, 2012).

The main factors linked to employees feeling undervalued at work included having fewer opportunities for involvement in decision making, being less satisfied with potential growth and advancement, having fewer opportunities to use flexible work arrangements and receiving inadequate monetary compensation and non-monetary rewards. Studies indicated that major means of making the work enjoyable and improving employee morale includes implementing casual dress days, employee recognition and reward program and providing complementary gifts and benefits to employees.

It is proven that higher employee engagement has a direct effect on patients. Patients received higher and improved quality of care, their satisfaction increased and their loyalty to the organisation was enhanced. Patients are more likely to also recommend the hospital to their friends or family if they had a pleasant experience.

There are different ways of improving the motivation and morale of the employees like recognizing employee performance, fun celebrations, inviting suggestions from employees for quality improvement, building trust among employees, reducing work stress among employees, employee development opportunities etc. Each of these initiatives has got its own merits and demerits. Hospitals can choose those initiatives which they feel will increase the motivation and satisfaction of its employees.

Hence, it is clearly evident that the satisfaction level of employees at a hospital has got significant impact on the patient care quality which in turn determines the patient satisfaction and loyalty to a hospital. The satisfaction level of employees, to a large extent, is dependent on the human resources management practices and Human Resource Development climate prevailing at the hospital. As such the present study tries to examine the perception of doctors regarding the Human Resource Development practices and the perception of patients and bystanders regarding the quality of care provided at government hospitals in Kerala.
1.9 Statement of the research problem

Though the government has been spending large amount of money for providing better health care services in our country, it is still debatable whether the government could measure up to the expectations of the various other stakeholders in this sector, especially the general public regarding the delivery of better health care services. The important question is what is lacking in the system and the basic issues to be tackled to improve the scenario. Primarily, one has to accept the fact that, there is still the need to fortify the basic infrastructural facilities in most of the government hospitals in the country. The dearth of the required number of qualified medical personnel is another major issue. One could still pose another pertinent question in this regard. This is regarding whether the available work force in government hospitals is really motivated, disciplined, well rewarded and responsible. Are they aware about their duties and responsibilities to the society at large? Are they discharging their duties honestly aimed at providing better health care services to the people within their limitations? Questions on the above line would compel us to ponder over the issues in depth to find out possible answers. It is generally agreed that, to provide better health care services to the people, there has to be a set of satisfied work force in the hospitals comprising of medical, paramedical and attending staff. A satisfied employee is generally considered to be a productive and committed employee. Therefore, one of the prerequisites of an effective health care delivery system is the existence of satisfied and committed work force in the health care sector. All this underlines the importance of implementation of effective HRD practices in the hospitals. In other words, the development of the human resources is very vital to achieve the task of provision of better health care. In essence, i) it is needed to improve the efficiency of existing health care infrastructure at the primary, the secondary and the territory levels and ii) a new vision is needed to promote the development of human resources in health care sector in tune with the current day requirements.

This study tries to analyse the patients' satisfaction of the service quality in the government hospitals and also to assess the perception of doctors regarding the extent of HRD practices existing at government hospitals across government hospitals in Kerala.
1.10 Limitations of the study

Though the researcher had taken all possible precautions to ensure that the study was carried out in a flawless manner, still the study has few limitations. The results of the study were solely based on the inputs provided by a sample of 240 doctors and 330 patients and bystanders from 9 hospitals out of the 26 hospitals. Though this sample size is statistically adequate to obtain reliable results, the sample may not be truly representative. Moreover, it is to be noted that the samples were selected at the convenience of the researcher. Similarly inputs were sought from doctors regarding various aspects like the kind of work environment, extent of support from superiors etc. Though confidentiality of responses were assured to the doctors, it is obvious that there would be a positive inclination in the responses provided, especially on questions relating to their superiors, out of their belief that their responses would be reported to their higher authorities. Also in the case of patients and bystanders, the researcher tried to solicit their opinion regarding the doctors, nurses and support staff under whom they are currently getting treated. As such, the patients and bystanders in general were hesitant to provide negative comments about the doctors, nurses or support staff out of the fear that any negative comments provided by them may affect the quality of care provided to them. Hence, the results obtained by analysing these data may not always reveal the true picture. As such, the findings of the study should be generalized with caution. However, there is always scope to verify the validity of the findings of the present study by undertaking similar studies in private and co-operative sectors. There is also a scope to extend the study to other states or even to a national level. The researcher has completely excluded the views of outpatients while assessing the quality of service delivery as well as nurses and support staff in assessing the HRD climate at hospitals. The study has also excluded various public health care institutions like Taluk hospitals, community health centres, primary health centers etc from the purview of the study.
1.11 Operational definitions of key terms used in this study

- **Human Resource Development**: The process of increasing the knowledge, skills, and the capacities of the people/employees in an organisation.

- **Human Resource Development Practices**: All the activities undertaken to improve employee performance.

- **Patient Care Quality**: Quality of health care services provided to inpatients.

- **Patients**: In patients who are getting treated and have spent at least two days at a stretch at the hospital.

- **Patient Centered Care**: Care process that is focussed on needs and preferences of patients.

- **Bystanders**: Bystanders who have accompanied the inpatients for a minimum of two days at a stretch.
1.12 Organisation of rest of the thesis

Apart from this introductory Chapter I, the thesis is organized in the following way.

Chapter II: Theoretical Framework of the Study

This chapter provides an overview of the various theoretical concepts relating to Human Resource Development as well as patient care quality used in the present study.

Chapter III: Review of Related Literature and Research Gap

This chapter provides a comprehensive review of the existing literature relating to Human Resources Development and patient care quality. The chapter presents the research gap identified on the basis of review of literature.

Chapter IV: Research Methodology

The statement of the problem, scope of the study, objectives of the study, hypotheses, research design, development of data collection instrument, data collection procedures, sample size determination, sampling procedure, data analysis etc. are presented in this chapter.

Chapter V: Data Analysis and Interpretation

The chapter provides an overview of the profile of doctors, patients and bystanders who participated in the study as well as their views on HRD practices and quality of patient care at government hospitals. This chapter presents the results of analysis of the data collected through field surveys.

Chapter VI: Summary of Findings, Suggestions, Recommendations and Conclusion

This chapter presents a brief summary of findings. The chapter also offers few suggestions to improve the perception of doctors regarding the extent of HRD practices at government hospitals as well as to improve the quality of services offered at government hospitals. This chapter concludes with a brief narration about the managerial implications of the study.