CHAPTER-1: INTRODUCTION

1.1 INTRODUCTION

Human resource management is considered to be the most valuable asset in any organization. It is the sum-total of inbuilt abilities, acquired knowledge and skills represented by the talents and aptitudes of the employed persons who consist of of executives, supervisors, and the rank and file employees. It may be noted here that human resources should be utilized to the maximum possible level, in order to attain individual and organizational goals. It is thus the employee's performance which finally decides and accomplishment of goals. However, the employee performance is to a large extent, influenced by motivation and job satisfaction [89].

People join organizations with certain motives like security of income and job, better prospects in future, and satisfaction of social and psychological needs. Every person has different sets of needs at different times. It is the liability of management to recognize this basic fact and provide suitable opportunities and environments to people at work to satisfy their needs [105].

1.2 CONCEPT OF JOB SATISFACTION

The term job satisfaction figures significantly in any discussions on management of human resources. Job satisfaction refers to a person's feeling of satisfaction on the job, which acts as a motivation to work. It is not the self- satisfaction, happiness or self-contentment but the satisfaction on the job [46].

Job satisfaction is an individual's feeling regarding his or her work. It can be influenced by a massive amount of factors [5]. The term relates to the total association between an individual and the employer for which he is paid. Satisfaction does mean the simple feeling state accompanying the achievement of any goal, the end state is feeling accompanying the achievement by an impulse of its objective. The term Job satisfaction was brought to limelight by Hoppock (1935)[74]. Hoppock describes job satisfaction as, "any combination of psychological, physiological and environmental circumstances that

cause and person truthfully to say I am satisfied with my job." Job satisfaction has many dimensions. Commonly noted facets are satisfaction with the work itself, wages, and recognition, rapport with supervisors and coworkers, and chance for advancement. Each dimension contributes to an individual's overall feeling of satisfaction with the job itself, but different people define the "job" differently.

There are three important dimensions to job- satisfaction:

1. Job- satisfaction refers to one's feeling towards one's job. It can only be contingent but not seen.

2. Job satisfaction is often determined by how well outcomes meet or exceed expectations. Satisfaction in one's job means increased commitment in the accomplishment of formal necessities. There is greater enthusiasm to invest personal energy and time in job performance.

3. The terms job-satisfaction and job attitudes are typically used interchangeably. Both refer to effective orientations on the part of individuals towards their work roles, which they are presently occupying.

Attitudes endure generally. But job satisfaction is dynamic; it can decline even more quickly than it developed. Managers, therefore, cannot establish the conditions leading to high satisfaction now and then neglect it, for employee needs may change unexpectedly. Managers need to pay attention to job satisfaction persistently [56].

To grasp the meaning of a construct like job satisfaction, it seems logical to look at how it is defined in the literature. The search for a universal definition of job satisfaction is not a difficult one; it is an impossible one. Even though many researchers define job satisfaction, the definitions vary.

Lock (1969) defined total job satisfaction as "the pleasurable emotional state resulting from the appraisal of one's job achieving or facilitating one's values". He also claimed that job satisfaction was a function of what a person wanted from a job and what he

perceived it as offering [63]. Lawler (1973) also explained job satisfaction in terms of the difference between what people thought they should receive and what they perceived that they actually did receive [60]. Schultz (1982) defined job satisfaction as "the psychological disposition of people toward their work – and this involves a collection of numerous attitudes or feelings"[96]. Lofquist and Dawis (1991) defined satisfaction as "an individual's positive affective evaluation of the target environment; result of an individual's requirements being fulfilled by the target environment; a pleasant affective state; the individual's appraisal of the extent to which his or her requirements are fulfilled by the environment" [66]. Even though the definitions vary, a commonality among them seems to be that job satisfaction is a job-related emotional reaction. E.A. Locke (1976) defined job satisfaction is as a pleasurable or positive emotional state resulting from the appraisal of one's job or job experience [64]. Feldman and Arnold (1983) defined job satisfaction as the amount of overall positive affect (or feelings) that individuals have towards their jobs [26]. Kreitner and Kinicki (1995) described, job satisfaction is an affective or emotional response toward various facets of one's job [58]. This definition means job satisfaction is not a unitary concept. Davis and Newstrom (1989) explained job satisfaction is a set of favorable or unfavorable feelings with which employees view their work [18]. Andrew(1988) stated that job satisfaction is the amount of pleasure or contentment associated with a job [4].

1.3 IMPORTANCE OF JOB SATISFACTION

Spector (1997) presented three reasons to clarify the importance of job satisfaction. First, organizations can be directed by humanitarian values. Based on these values they will attempt to treat their employees honorably and with respect. Job satisfaction assessment can then serve as an indicator of the extent to which employees are dealt with effectively. High levels of job satisfaction could also be a sign of emotional wellness or mental fitness. Second, organizations can take on a utilitarian position in which employees' behavior would be expected to influence organizational operations according to the employees' degree of job satisfaction/dissatisfaction. Job satisfaction can be expressed through positive behaviors and job dissatisfaction through negative behaviors. Third, job

satisfaction can be an indicator of organizational operations. Assessment of job satisfaction might identify various levels of satisfaction among organizational departments and, therefore, be helpful in pinning down areas in need of improvement. Spector (1997) believed that each one of the reasons is validation enough of the significance of job satisfaction and that the combination of the reasons provides an understanding of the focus on job satisfaction [102].

Spector, of course, is only one of many researchers, scholars, and writers who addressed the importance of job satisfaction. His reasons appear to be representative of many views on the importance of the concept in other major works dealing with job satisfaction[32,41].

Employees' job satisfaction and their assurance have always been important issues for health care administrators. After all, high levels of absenteeism and staff turnover can affect the administrators' bottom lines, as temps, recruitment, and retaining take their toll[73]. Satisfied employees tend to be more creative, innovative, and devoted to their employers, and recent studies have shown a direct correlation between staff satisfaction and patient satisfaction in health care organizations [3]. The traditional model of job satisfaction focuses on all the feelings that a person has about his/her job [67]. However, what makes a job satisfying or dissatisfying does not depend only on the nature of the job, but also on the expectations that persons have of what their job should provide [102]. Continuously hiring new employees is costly, and frequent staff turnover affects employees' self-esteem and impairs patient care [101].

Job satisfaction of the health workers is highly important in building up employee motivation and efficiency as higher job satisfaction determine better employee performance and higher level of patients' satisfaction [76]. Job dissatisfaction resulting in burn out and turn over would aggravate the current shortage and results in serious under staffing of health care facilities. This has the potential to have a negative impact on the delivery of patient care because there is evidence to suggest that reduction in health professional employees below certain level is related to poor patient outcomes [28].

Job satisfaction improves the retention level of employees and reduces the cost of hiring new employees [77]. On the other hand, the outcome of job dissatisfaction is increase in the cost of recruitment, selection and training, dissuasion of current employees and reduction in the development of organization [84]. The dissatisfaction of the employees has adverse effect on the effectiveness of the organization change and the sustainability of change, depend on human qualities rather than on the quality of equipment or the quantity of money available. Improvements in health services require a motivated workers to execute them and to make sure their endurance during difficult times [27,69].

Researchers contend that job satisfaction is possibly the most important yet subtle factor in understanding worker motivation, performance and effectiveness, and recruitment and retention[13,100]. Usually utilized as a standard measure, researchers have established that job satisfaction is a important predictor of psychological well-being and of various other job characteristics (e.g., promotion opportunities, interpersonal relations and supervision) [80].

Workers who stated they were satisfied with their work had been found to be better than those who did not [81]. Earlier research suggests that job satisfaction and job performance were positively correlated [15]. Job satisfaction is correlated with patient satisfaction with the services they receive, patient acquiescence and continuity of care[98].

Work satisfaction has been viewed as a key indicator of welfare for employees, which has been found to be related to employees' psychosomatic states such as burnout [22], to employee's behaviour such as absenteeism, turnover and performance [112], as well as to the quality of car [33] and patient's behaviour [21].

The most important resource in every organization is its employed human possessions [57]. Nowadays, every organization is looking for some solution to improve the services offered to its consumers. Potential and developed organizations reassess behavior and communication with their employees as the first step in keeping them satisfied since studies specify that job satisfaction of employees leads to consumer satisfaction [2].

Saari and Judge (2004) in a review of studies stated “it does appear job satisfaction is, in fact a predictor of performance, and the relationship is even stronger for professional jobs”. The overall impression about one's job in terms of specific aspects of the job (e.g., compensation, autonomy, colleagues) can be associated with specific results, such as productivity [92]. Herzberg (1966) developed a two-factor theory of job satisfaction: "motivation" and "hygiene". According to Herzberg's theory, if handled appropriately, hygiene issues cannot motivate workers but can reduce dissatisfaction. Hygiene factors consist of organizational policies, supervision, salary, interpersonal relations and working conditions. They are variables associated to the worker's environment. A worker's job satisfaction is also prejudiced by situational factors related with the work itself, labeled intrinsic satisfaction. These consist of outcomes directly derived from work such as the nature of their jobs, accomplishment in the work, promotion opportunities, and chances for individual growth and recognition. Because such factors were related with high levels of job satisfaction, Herzberg referred to them as "motivation factors" [39].

Job satisfaction is a multidimensional, continuing, vital and much researched concept in the field of organizational behaviour [6]. The conception is a development of the human relations association that began with the classic Hawthorne studies in the late 1920s. There is a lack of consensus as to what job satisfaction is (Hall, 1986), and how the job satisfaction of employees should be assessed [35]. Buss (1988), for example, described job satisfaction as an employee’s view that his or her job allows the accomplishment of important values and needs [12]. In this regard, according to Siegel and Lane (1982), motivational theories, such as equity theory, Maslow’s need-hierarchy theory, and Herzberg’s two-factor theory, all have considerable implications for understanding job satisfaction. Herzberg’s theory is specially significant as it distinguished among general types of work motivations, namely, intrinsic motivators and extrinsic motivators [97]. These two groups of motivators were related with job satisfaction and dissatisfaction, respectively [10,38]. Locke (1976) listed the general aspects of job satisfaction as work, pay, promotions, recognition, benefits, working conditions, supervision, co-workers, company, and management [64]. Consequently research indicated that these different aspects could be split according to Herzberg’s two dimensions [40,102]. Intrinsic satisfaction

refers to job tasks and job content (such as variety, autonomy, skill utilization, self-fulfilment and self-growth), and extrinsic motivation refers to other factors such as pay, co-workers, and work conditions [10]. Herzberg (1959) also made a difference between satisfiers and dissatisfiers. If factors such as working conditions and supervisors are good, they are alleged as satisfiers, and vice versa. However, they are not alleged as motivators. Motivators consist of such things as opportunity for advancement and promotion, greater responsibility, opportunity for growth, and interesting work[38].

The healthcare workforce crisis has been having an impact on many countries' ability to fight disease and get better health [82]. Correct evaluation of job satisfaction became essential for any organization in their meta-analysis, for improving employees' physical and mental well-being [25]. Insufficient human resources are a major restraint to improving global health [79,107]. Job satisfaction has been conceptualized both globally (general satisfaction with a job) and dimensionally (satisfaction with specific dimensions of a job such as remuneration, promotion, and relationships with colleagues) [87]. Job satisfaction is of interest because it is an essential determinant of the performance of health professionals [23]. Job satisfaction can be considered as a global feeling about the job or as a related collection of attitudes about various aspects or facets of the job. The global approach and the facet approach can be used to get a complete picture of employee's job satisfaction [102].

According to Schermerhorn the importance of job satisfaction can be viewed in the perspective of two decisions people make about their work. The first is the decisions to fit in- that is, join and remain a member of an organization. The second is the decision to execute- that is, to work hard in pursuit of high levels of task performance. Job satisfaction influences absenteeism or the failure of people to be present at work. Job satisfaction can also have an effect on turnover or decisions by people to cease their employment [95].

There are important reasons why the researchers should be apprehensive with job satisfaction. The first is that people ought to have to be treated moderately and with

deference. Job satisfaction is to some level an evidence of good management. It can also be considered as an indicator of emotional well-being or physiological wellbeing. The second reason is that job satisfaction can lead to performance of employees that affects organizational performance. Differences amongst organizational units in job satisfaction can be analytic of prospective trouble spots [102].

Dissatisfied workers are more likely to provide substandard services, the physical and mental status, and the social performance of these workers can be affected significantly by the level of their job satisfaction [72]. However, as Schermerhorn points out, only job satisfaction is not a consistent interpreter of individual work performance.

Job satisfaction is an emotional state that is attained on achieving the results at which the individual is aim [67]. Recruiting new staff while maintaining a strong commitment to the organization among current staff is a considerable challenge for the health care sector. In the future, it will be necessary to prioritize job satisfaction in health care if hospitals are to make sure sufficient staffing by maintaining high levels of commitment among existing employees although recruiting new staff [75,52].

Research has asserted that high levels of job satisfaction among health-care professionals might develop the association among medical providers and patients, which are contributive to the outcomes of medical services [37].

People spend a sizeable proportion of their waking lives in the work environment and would want that portion of their lives to be pleasant, agreeable and fulfilling.

A major reason for attaching so much importance to job satisfaction is its relationship to mental health. In the realm of one's subjective inner world, discontent about specific parts of one's lives tends to have a 'spill over' effect and to colour one's outlook even upon otherwise unrelated portions of one's life space. Dissatisfaction with one's job seems to have an especially volatile 'spill over' effect. People who feel bad about their work are apt to feel bad about many things including leisure activities and even life itself (Hammer & Organ 1978; Singh & Dewan 1983; Nair & Kulkarni 1984 and Hene &

Locke 1985). Evidence also points to a relationship between job dissatisfaction psycho-somatic symptoms and physical ill health [94].

Realizing the importance of job satisfaction the present investigation focuses on job satisfaction and plans to study its relationship with socio demographic variables and other factors.

1.4 THEORETICAL FRAMEWORKS OF JOB SATISFACTION

Three theoretical frameworks of job satisfaction can be identified in the literature. Framework one is based on content theories of job satisfaction. Framework two is grounded in process theories of job satisfaction. Framework three is rooted in situational models of job satisfaction[106].

1.4.1 Framework One: Content Theories

Content theorists assume that fulfillment of needs and attainment of values can lead to job satisfaction [64]. Maslow's (1954) need hierarchy theory and Herzberg's motivator-hygiene theory (Herzberg, 1966) are examples of content theories.

Maslow's Need Hierarchy Theory: According to Maslow's (1954) view of individual needs, job satisfaction is said to exist when an individual's needs are met by the job and its environment. The hierarchy of needs focuses on five categories of needs arranged in ascending order of importance. Physiological, safety, belongingness and love are the lower-level needs in the hierarchy. The higher-level needs are esteem and self-actualization. When one need is satisfied, another higher-level need emerges and motivates the person to do something to satisfy it. A satisfied need is no longer a motivator [71].

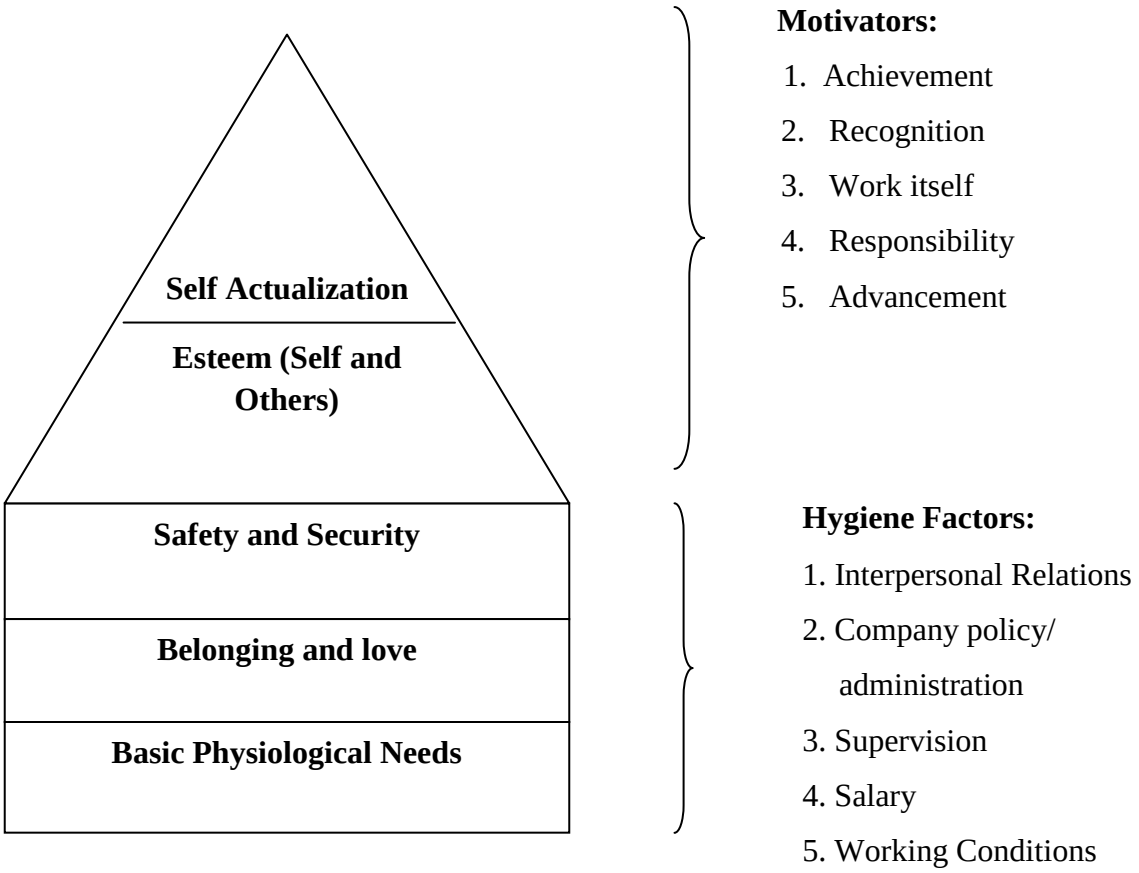
Whaba and Bridwell (1976) did an extensive review of the research findings on the need hierarchy concept. The results of their review indicate that there was no clear evidence showing that human needs are classified into five categories, or that these categories are structured in a special hierarchy. Even though hardly any research evidence was discovered in support of the theory, it enjoys wide acceptance [109].

Herzberg's Motivator-Hygiene Theory: The study of job satisfaction became more sophisticated with the introduction of Herzberg's motivator-hygiene theory [38,39]. This theory focuses attention upon the work itself as a principal source of job satisfaction. To Herzberg the concept of job satisfaction has two dimensions, namely intrinsic and extrinsic factors. Intrinsic factors are also known as motivators or satisfiers, and extrinsic factors as hygienes, dissatifiers, or maintenance factors. The motivators relate to job content (work itself) and include achievement, recognition, work itself, responsibility and advancement. The hygienes relate to job context (work environment) and involve, for example, company policy and administration, supervision, salary, interpersonal relations, and working conditions. Motivators are related to job satisfaction when present but not to dissatisfaction when absent. Hygienes are associated with job dissatisfaction when absent but not with satisfaction when present.

Before the emergence of the motivator-hygiene theory, only single scales had been used to measure job satisfaction. Scores on the high end of the scale reflected high levels of job satisfaction, whereas scores on the low end represented high dissatisfaction. Research based on the motivator-hygiene theory should apply different scales for job satisfaction and dissatisfaction because the opposite of job satisfaction is no job satisfaction and the opposite of job dissatisfaction is no job dissatisfaction [48].

Assessing the motivator-hygiene theory, Locke, Fitzpatrick, and White (1983) pointed out that Herzberg's theory is method dependent. Herzberg used what is known as the critical incident technique in the development of his theory. This type of research approach has been the only one consistently leading to results confirming the theory. The results of other applied methods have indicated that hygienes indeed can be associated with job satisfaction and motivators with job dissatisfaction [65].

Figure 1.1: Maslow's and Herzberg's Ideas compared



1.4.2 Framework Two: Process Theories

Process theorists assume that job satisfaction can be explained by investigating the interaction of variables such as expectancies, values, and needs [32]. Vroom's expectancy theory, Adams' equity theory (1963), theory by Lyman Porter and E.E Lawler are representative of the second framework.

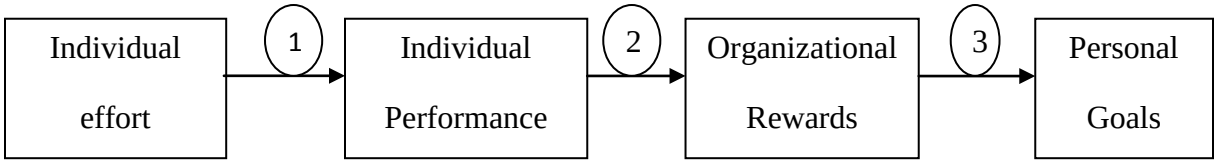
Vroom's Expectancy Theory: Vroom's expectancy theory suggests that people not only are driven by needs but also make choices about what they will or will not do. The theory proposes that individuals make work-related decisions on the basis of their perceived

abilities to perform tasks and receive rewards. Vroom established an equation with three variables to explain this decision process. The three variables are expectancy, instrumentality, and valence.

Expectancy is the degree of confidence a person has in his or her ability to perform a task successfully. Instrumentality is the degree of confidence a person has that if the task is performed successfully, he or she will be rewarded appropriately. Valence is the value a person places on expected rewards.

Expectancy, instrumentality, and valence are given probability values. Because the model is multiplicative, all three variables must have high positive values to imply motivated performance choices. If any of the variables approaches zero, the probability of motivated performance also approaches zero. When all three values are high, motivation to perform is also high. Vroom's expectancy theory suggests that both situational and personality variables produce job satisfaction [108].

Figure 1.2: Expectancy Theory



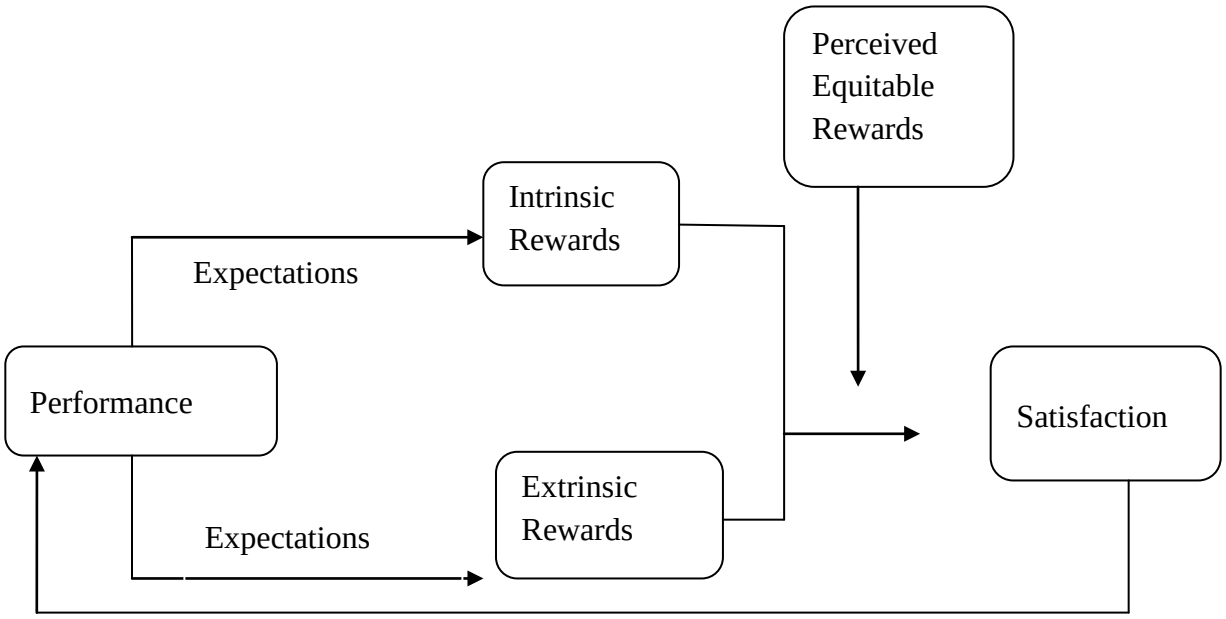
1 Effort-Performance relationship
2 Performance-Reward relationship
3 Rewards-Personal goals relationship

Adams' Equity Theory: The primary research on equity theory was done by Adams (1963). Equity theory proposes that workers compare their own outcome/input ratio (the ratio of the outcomes they receive from their jobs and from the organization to the inputs they contribute) to the outcome/input ratio of another person. Adams called this other person "referent." The referent is simply another worker or group of workers perceived to

be similar to oneself. Unequal ratios create job dissatisfaction and motivate the worker to restore equity.

When ratios are equal, workers experience job satisfaction and are motivated to maintain their current ratio of outcomes and inputs or raise their inputs if they want their outcomes to increase. Outcomes include pay, fringe benefits, status, opportunities for advancement, job security, and anything else that workers desire and receive from an organization. Inputs include special skills, training, education, work experience, effort on the job, time, and anything else that workers perceive that they contribute to an organization [1].

Figure 1.3: Porter and Lawler Motivation Model



Process theory by Lyman Porter and E.E Lawler focuses on the value a person puts on a goal as well as the person's perception of workplace equity, or fairness, as factors that influence his or her job behavior. In a work situation, perception is a way an individual views the job. Figure 1.3 contains a simplified Porter and Lawler motivation model, which indicates that motivation is influenced by people's expectations. If expectations are not met, people may feel that they have been unfairly treated and consequently become dissatisfied. The essence of a Porter and Lawler view of a motivation is perception. In

addition, as the feedback loop in figure 1.3 indicates, performance leads to satisfaction leading to performance [24].

1.4.3 Framework Three: Situational Models

Situational theorists assume that the interaction of variables such as task characteristics, organizational characteristics, and individual characteristics influences job satisfaction [43]. Examples of models are the situational occurrences theory of job satisfaction [88] and predictors of job satisfaction [30].

Situational Occurrences Theory: The situational occurrences theory of job satisfaction was proposed by Quarstein et al (1992). The two main components of the theory are situational characteristics and situational occurrences. Examples of situational characteristics are pay, promotional opportunities, working conditions, company policies, and supervision. Individuals tend to evaluate situational characteristics before they accept a job.

Situational occurrences tend to be evaluated after accepting a job. Situational occurrences can be positive or negative. Positive occurrences include, for example, giving employees some time off because of exceptional work or placing a microwave in the work place. Negative occurrences include, for example, confusing email messages, rude remarks from coworkers, and copiers which seem to break down a great deal. Quartstein et al. (1992) hypothesized that overall job satisfaction is a function of a combination of situational characteristics and situational occurrences. The findings of their study supported the hypothesis. According to the researchers, a combination of situational characteristics and situational occurrences can be a stronger predictor of overall job satisfaction than each factor by itself [88].

1.5 MODELS OF JOB SATISFACTION

Different models for understanding and explaining job satisfaction were also developed. Lawler's (1973) model of facet satisfaction, for example, is directly related to equity theory. According to his model, employees are satisfied with a particular facet of their job

(e.g. co-workers, supervisors, pay) when the amount of the facet they observe that they should obtain for performing their work at least equals the amount they really receive [60]. Locke's (1969) discrepancy theory, on the other hand, explains job satisfaction in terms of needs. It focuses on satisfaction and dissatisfaction with a job, and states that satisfaction, or dissatisfaction, with some facet of a job depends on the perceived congruence or discrepancy between desires (needs) and outcomes (what is received), and the importance of what is required [63]. On the whole job satisfaction is the sum of each of the aspects of the job multiplied by the importance of the aspect for a person.

Job Characteristics Model

The job characteristics model (JCM) argues that jobs that contain intrinsically motivating characteristics will lead to higher levels of job satisfaction [34]. Five core job characteristics define an intrinsically motivating job:

1. Skill variety- The degree to which the job requires a variety of different activities so the worker can use a number of different skills and talent or extent to which job allows one to do different tasks;

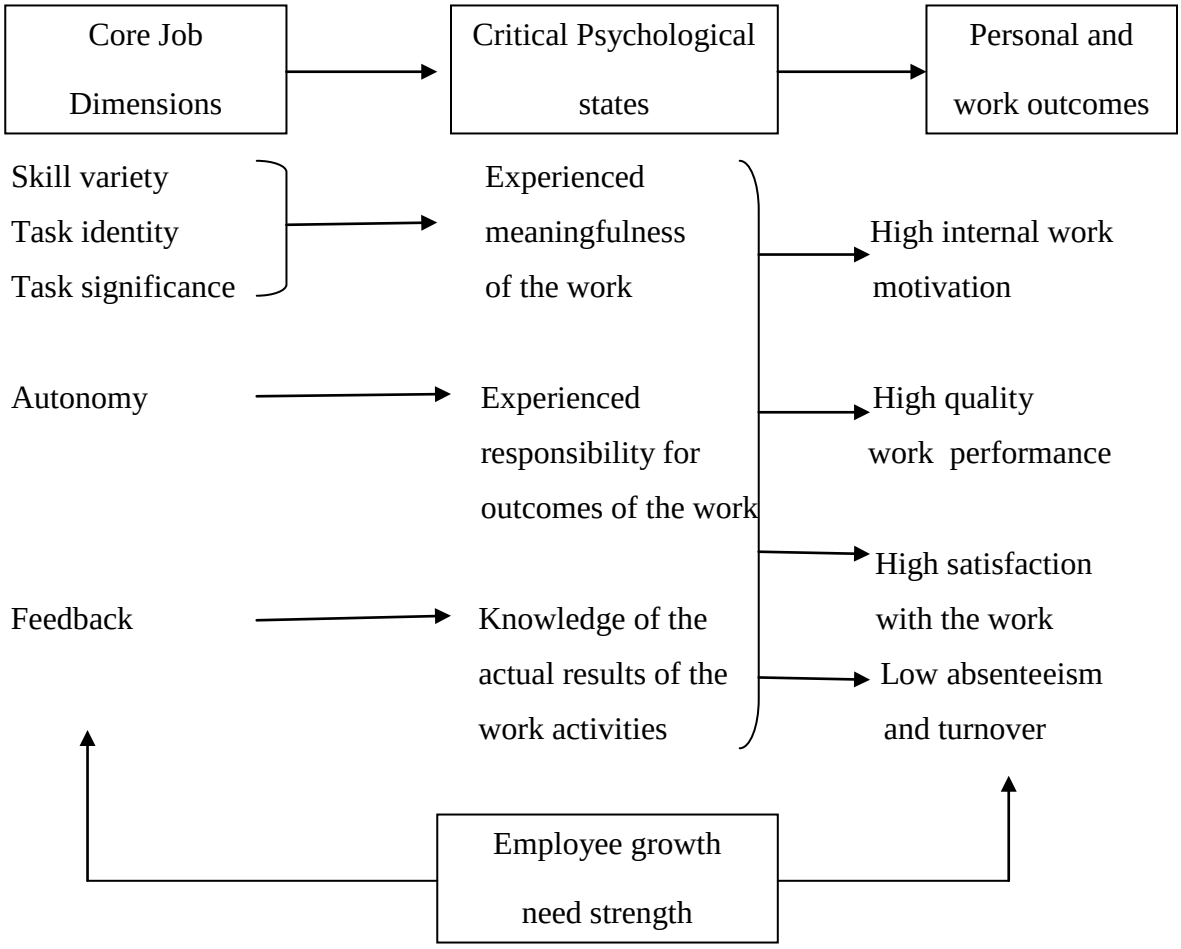
2. Task identity- The degree to which the job requires completion of a whole and identifiable piece of work or degree to which one can see one's work from beginning to end;

3. Task significance- The degree to which the job has a substantial impact on the lives or work of other people or degree to which one's work is seen as important and significant;

4. Autonomy- The degree to which the job provides substantial freedom, independence, and discretion to the individual in scheduling the work and in determining the procedures to be used in carrying it out or degree to which one has control and discretion over how to conduct one's job; and

5. Feedback- The degree to which carrying out the work activities required by the job results in the individual obtaining direct and clear information about the effectiveness of his or her performance or degree to which the work itself provides feedback for how one is performing the job.

Figure 1.4: Job Characteristics Model



Source: J.R. Hackman and G.R. Oldham, Work Redesign, 1980, pp 78-80.

According to the theory, jobs that are enriched to provide these core characteristics are likely to be more satisfying and motivating than jobs that do not provide these characteristics. More specifically, it is proposed that the core job characteristics lead to three critical psychological states--experienced meaningfulness of the work, responsibility for outcomes, and knowledge of results-which, in turn, lead to outcomes such as job satisfaction.

There is both indirect and direct support for the validity of the model's basic proposition that core job characteristics lead to more satisfying work. In terms of indirect evidence, research studies across many years, organizations, and types of jobs show that when employees are asked to evaluate different facets of their job, such as supervision, pay, promotion opportunities, coworkers, and so forth, the nature of the work itself generally emerges as the most important job facet [53,54]. In addition, of the major job satisfaction facets-pay, promotion opportunities, coworkers, supervision, and the work itself-satisfaction with the work itself is almost always the facet most strongly correlated with overall job satisfaction, as well as with important outcomes such as employee retention (e.g., Frye, 1996; Parisi & Weiner, 1999; Rentsch & Steel, 1992; Weiner, 2000) .

Value-Percept Model

Locke (1976) argued that individuals' values would determine what satisfied them on the job. Only the unfulfilled job values that were important to the individual would be dissatisfying. According to Locke's value-percept model, job satisfaction can be modeled by the formula

$S = (V_c - P) \times Vi$

or

Satisfaction = (want - have) X importance

where S is satisfaction, V_c is value content (amount wanted), P is the perceived amount of the value provided by the job, and V_i is the importance of the value to the individual. Thus, value-percept theory predicts that discrepancies between what is desired and what is received are dissatisfying only if the job facet is important to the individual. Because individuals consider multiple facets when evaluating their job satisfaction, the cognitive calculus is repeated for each job facet. Overall satisfaction is estimated by aggregating across all contents of a job, weighted by their importance to the individual.

The value-percept model expresses job satisfaction in terms of employees' values and job outcomes. A particular strength of the model is that it highlights the role of individual differences in values and job outcomes. However, one potential problem with the value-percept theory is that what one desires (V_c or want) and what one considers important (V_i or importance) are likely to be highly correlated. In addition, the use of weighting may be

inappropriate unless weighting variables are measured with very high reliability. The model also ignores influences from exogenous factors, such as costs of holding a job, or current and past social, economic, or organizational conditions external to the individual/ job nexus [64].

Cornell Model

Hulin, Roznowski, and Hachiya (1985) and Hulin (1991) provide a model of job satisfaction that attempts to integrate previous theories of attitude formation. The model proposes that job satisfaction is a function of the balance between role inputs-what the individual puts into the work role (e.g., training, experience, time, and effort) and role outcomes what is received by the individual (pay, status, working conditions, and intrinsic factors). All else equal, the more outcomes received relative to inputs invested, the higher work role satisfaction will be. Furthermore, according to the Cornell model, an individual's opportunity costs affect the value the individual places on inputs. In periods of labor oversupply (i.e., high unemployment), individuals will perceive their inputs as less valuable due to the high competition for few alternative positions, and the opportunity cost of their work role declines (i.e., work role membership is less costly relative to other opportunities). Therefore, as unemployment (particularly in one's local or occupational labor market) rises, the subjective utility of inputs falls making perceived value of inputs less, relative to outcomes thus increasing satisfaction. Finally, the model proposes that an individual's frames of reference, which represent past experiences with outcomes, influence how he or she perceives current outcomes received. This concept of frames of reference, as generated and modified by individuals' experience, accounts, in part, for differences in job satisfactions of individuals with objectively identical jobs. However, direct tests of the model are lacking [44,45].

1.6 FACTORS OF JOB SATISFACTION

Research tends to divide the characteristics of work into two broad categories: extrinsic variables and intrinsic variables. In 1959 Herzberg et al. made the distinction between the intrinsic rewards from the job and the extrinsic rewards from the job. The intrinsic factors refer to a job’s innate features, people’s affective reactions to features important to the

work itself. The extrinsic work factors focus on issues that are external to the job itself, such as pay [59]. The difference between intrinsic and extrinsic work factors, rewards, motives, needs etc remains to be a useful tool in studies of many researchers.

Stress has a cost for individuals in terms of health, well-being and job dissatisfaction, as well as for organizations in terms of absenteeism and turnover, which in turn may impact upon the quality of patient care [86].

Hospital employees have difficulties in meeting the needs of their patients if their own needs are not met [62,83]; therefore hospital managers have responsibilities to both staff and patients [36]. Managers of health services organizations must elicit cooperation and performance from their staff in order to ensure quality of care to patients [70].

Most research on job satisfaction has focused on the effects of job enrichment and job design, or the quality of work life. As a human resource manager is concerned about balancing job satisfaction with performance, he needs to know how to foster an organizational climate that contains these elements.

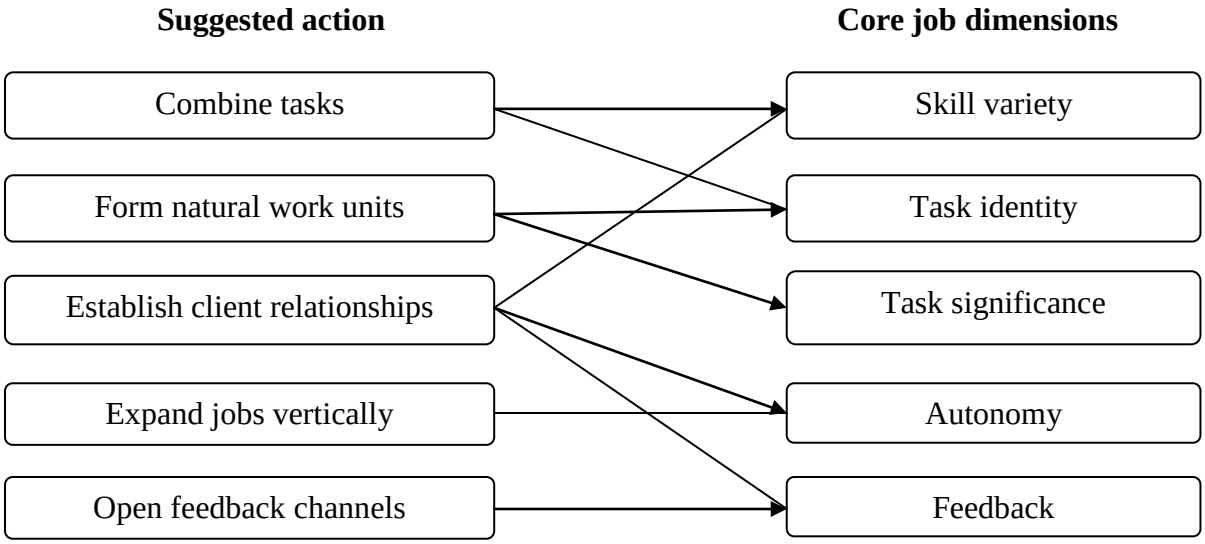
Job enrichment

An "enriched" job refers to the vertical expansion of jobs. It increases the degree to which the worker controls the planning, execution, and evaluation of his or her work. An enriched job organizes tasks so as to allow the worker to do a complete activity, increases the employee's freedom and independence, increases responsibility, and provides feedback so an individual will be able to assess and correct his or her own performance [34]. Enriched jobs contain five core work dimensions: task identity, task significance, skill variety, autonomy, and feedback. The presence of these psychological states leads ultimately, to motivation, high quality performance, low absenteeism and turnover and high job satisfaction. Management can enrich employee's job by Combining tasks- it takes existing and fractionalized tasks and puts them back together to form a new and larger module of work; Forming natural work units- it means that the tasks an employee does create an identifiable and meaningful whole; Establishing client relationships- it increases the direct relationships between workers and their clients;

Expanding jobs vertically gives employees responsibilities and control that were formerly reserved for management; Opening feedback channels- it lets employees know how well they are performing their jobs and whether their performance is improving, deteriorating, or remaining at a constant level.

An employee who can point to a product and boast, “I made that” or “my efforts produced that” is expecting task identity. If employees also consider the fruit of their labors to be important, then task significance is part of their job. A task is significant when employees believe that what they have they have done makes a real difference to someone or to the public. Autonomy is experienced by those who are confident to the work without close supervision; skill variety means they do a lot of diverse things on the regular basis; and feedback presupposes regular and correct information on how work is alleged by those for whom it is done.

Figure 1.5: Guidelines for Enriching Job



Source: J.R. Hackman and J.L. Suttle(eds), Improving Life of work(Glenview, IL Scott Foresman, 1997), p-138.

An example of an enriched job is that of a small city municipal employee who has accountability for the general operations of government. The municipal employee’s job requires the conventional duties of a manager; planning; organizing, staffing, directing,

coordinating, reporting, and budgeting (POSDCORB). Job enrichment among managerial and professional employees is often innate in the nature of their work. Those who perform support functions and operate the organization's knowledge are those for whom job enrichment is difficult, though not always unattainable.

Hospital employees are examples of those for whom routinized, specialized job requirements are being changed. Today, in many medical facilities, a patient is assigned a "Nurse Coordinator" who is involved from the beginning to end of treatment and is thus able to obtain satisfaction from seeing a patient improve as a result of his or her ministrations. Liability for a maternity patient used to move from labor room staff to delivery room to recovery room to maternity ward, with no one knowing what happened after she left their case. In a situation in which employee jobs are enriched, the pregnant woman comes to a birthing area where the same staffs provide continuity of service and see the results of their labors. This environment enriches both the lives of the employees and the situation of the woman.

Quality of work life

Another way to enhance job satisfaction among employees is to provide a high quality of work-life (QWL) environment, in which employees may be fruitful because their work situations is one in which they find pleasure. A QWL environment may contain either routinized jobs or enriched jobs. The key to QWL is the institutionalization of the following components, all within the employer's purview:

1) Fair and ample compensation;

2) Safe and vigorous work environment;

3) Opportunities to build up human capacities by performing meaningful work and telling new ways of doing job tasks;

4) Growth and security, which includes opportunities to get better knowledge, skills, and abilities, and a sense of job security;

5) Social integration, which includes the opportunity to act together favorably with both co-workers and manager;

6) Constitutionalism, which includes personal policies that are administered fairly, a work environment free of persecution, and the same opportunities for employees to advance;

7) Total life space, which includes the ability to balance the demands of home and work; and

8) Social relevance, which includes pleasure in both the job and the employer.

A high quality of work life can result from a strong-minded effort on the part of a human resource manager. It may also exist simply as a result of fretful executives and skilled managers who display "good management". The presence of QWL factors in an organization sets the stage for job satisfaction to happen. The factors are a backdrop besides which the activities of both employees and supervisors take place. Without them the work environment can be uncomfortable, even unfriendly. With QWL factors in place, the real business of balancing job satisfaction and performance can start. If quality working conditions are not there, people will become dissatisfied. They may look for other jobs. They may simply execute at a minimal level. In either event, the organization will lose. What employees at all levels of the organization want is "good work" is not only a job, but also a source of monetary support; that is:

- Work that allows people to use the skills that are exclusive and special to them;
- Work that allows people to be in contact with one another at the work place; and
- Work that allows people to create something that is "good" something to which they can look with conceit, something that has social relevance [111].

Quality of work life is a multi-faceted concept and its assertion is having a work environment where an employee's activities become more important [99]. Alert and conscientious human resource managers, reviewing the working environment in their organizations, can determine and prevent uncomfortable conditions. This means implementing procedures or policies that make the work less routine and more worthwhile for the employee. These procedures or policies include autonomy,

recognition, belonging, progress and development, and external rewards. Elements of QWL that can persuade directly are total life space, good managerial relations, fair and adequate compensation, and safe and healthy work environment. The researcher considered above and explains them one by one as follows:

1. **Total Life Space:** The idea of "total life space" is a new concept for human resource managers, increasing in importance as the number of employees grow. Employees want to be able to stabilise the demands of work and home. To do this, they want their managers to expect a reasonable amount of work, but not so much that the job interferes with personal life.

2. **Good Managerial Relations:** The second most important factor in development of job satisfaction is "good managerial relations". Those who act to maintain good relations with their employees reveal the following behaviors: help with job related problems, awareness of employee difficulties, good communication, and regular feed-back about the performance so that employees always know where they stand. Employees want to have input into decisions that involve them and to feel important. They want to be informed and involved. When a job brings recognition and respect, employees experience satisfaction with it. This is a simple condition to create with feedback.

3. **Fair and Adequate Compensation**: Adequate compensation is another important influence on employee job satisfaction. Employees expecting fair and adequate compensation- a day's pay for a day's work. The component of compensation that influences satisfaction appears to be "equity" to a certain extent than amount however. Satisfaction with wages is more reliant on relative than on absolute pay, on comparison with others, and on perceptions of fairness. While within organizations there is a association between job satisfaction and pay, it is very small. Employees are constantly more satisfied because of equity than they are because of high wages. Employees at work have a clear thought of what they have

to to be paid in comparison with others, and in relation to their skill, and experience, and so fourth. They want their performance, seniority, age, and education to be recognized and rewarded.

4. **Work Environment:** Employee job satisfaction is also prejudiced by the quality of the working environment both its physical attributes and the degree to which it provides meaningful work. While a comfortable physical environment is correlated with job satisfaction, the relationship is not simply as strong as the relationship between satisfaction and managerial behavior. Employees want certain conditions in their work they want to believe that what they do will finally make a difference to somebody in someway. They want to take part in decision making, opportunities to grow and develop, and same opportunities for their coworkers regardless of race, sex, or age [47].

The Role of Managers: The evidence that "good management" plays a part in affecting employee job satisfaction puts a responsibility on both the managers and the supervisors in the organization (Ibid). Management needs information on employee job satisfaction in array to make sound decision, both in preventing and solving employee problems .A typical method used is a job satisfaction surveys, also known as a morale, opinion, attitude, or quality-of-work-life survey. A job satisfaction survey is process by which employees report their feelings towards their jobs and work environment. Individual responses are then combined and analyzed [78].

1.7 HOSPITALS IN INDIA

Pre Independence Period (Before 1947)

Early Indian rural considered the provision of institutional care to the sick as their spiritual and temporal responsibility. The forerunners of the present hospitals can be traced to the times of Buddha, followed by Ashoka. The Indian system of Medicine Ayurveda was prevalent that is Sushruta (6^{th} century B.C.) the famous surgeon who wrote Shushruta Samhita and Charaka (200 A.D.) the famous physician who wrote Charak

Samhita. Their works are considered as standards for many centuries with instructions for creation, of hospital, for provisions in lying and children rooms, maintenance and sterilisation of bed linen with steam and fumigation. Medicine based on Indian system was taught in the University of Taxila.

The most notable of the early hospitals were those built by king Ashok (273-232 BC). There were rituals laid down for the attendants and physicians who were enjoined to wear white clothes and promise to keep the confidence of the patients. In 10 century the age of Indian medicine started to decline from the Mohammedan invasion. They brought Yunani (Greek) system of Medicine.

The modern system of Medicine in India was introduced in 17^{th} century with the arrival of European Christian missionaries in South India. In 1664 the East India company established its first hospital for soldiers at Chennai and in (1668) for civilian population. European doctors were getting popular in 18^{th} and 19^{th}century. Organized medical training was started with the first medical college in Calcutta in 1835 followed by Chennai in 1850. In the British period local government and local self government bodies were encouraged to start dispensaries at tehsil and district level. In 1885 there were 1250 hospitals and dispensaries in British India. But the medical care scarcely reached 10 per cent of population in India.

Emergence of Health Care Delivery System and Hospitals in India (After 1947)

The health scenario in 1947 was unsatisfactory. The bed to population ratio was 1:4000, doctor to population ratio 1:6300 and nurse to population ratio 1:40,000.

After independence various committee were setup like Bohr committee (1943), Mudalidar committee (1959), Hospital Areview committee (`1963). This committee made extensive recommendations in the following areas.

Although the population was distributed in urban & rural in the proportion of 20:80, a great depravity existed in the facilities available in urban and rural areas.

1.Provision of adequate preventive, promotive and curative services to all in the form of comprehensive health care (integration of services).

2. Delivery of this comprehensive health care through an infrastructure of hospital dispensaries and by opening primary health care (PHC) centers at block level, and taluka level hospitals.

3. Development of adequate communication in rural areas.

4. Demarcation of health services into two groups, viz. personal and impersonal.

5. Fitting the above concepts into a short-term plan and a long-term plan.
The short term plan envisaged a province wise organization for the combined preventive and curative health work through establishment of a number of primary, secondary and district health units. The impersonal health services were to include town and village planning, housing, water supply, drainage and general sanitation. The bed to population ratio was planned about 1.03 per 1000 population at the end of 10 years.
The long term plan envisaged a primary Health Care Centre for every 40,000 population with a 30 bedded rural hospital to serve for primary Health Care Centers. The bed: population ratio is 1 bed per 1000 population.

6. The administrative structure should be tripartite:
(a)Clinical
(b)nursing
(c)business administration

7. The following bed capacity should be attained :
Teaching hospitals – at least 500
District hospitals – At least 200
Tehsil hospital – At least 50

8. In case where distances are long and communication is difficult such as hill districts, certain tehsil hospital should be developed as fully fledged centres.

1.7.1 CHANGING ROLE OF HOSPITALS

From its gradual evolution through the 18th and 19th centuries, the hospital both in the eastern and the western world-has come of age only recently during the past 50 years or so, the concept of today's hospital contrasting fundamentally from the old idea of a hospital as no more than a place for the treatment of the sick. With the wide coverage of every aspect of human welfare was part of health care-viz. physical, mental and social well-being, a reach-out to the community, training of health workers, biosocial research, etc.-the health care service have undergone a steady metamorphosis, and the role of hospital has changed, with the emphasis shifting from :

1. Acute to chronic illness.

2. Curative to preventive medicine.

3. Restorative to comprehensive medicine.

4. Inpatient care to outpatient and home care.

5. Individual orientation to community orientation.

6. Isolated function to area-wise or regional function.

7. Tertiary and secondary to primary health care.

8. Episodic care to total care.

The important factors which have led to the changing role and functions of the hospital are as follows:

- Expansion of the clientele from the dying, the destitute, the poor and needy to all classes of people.
- Improved economic and social status of the community.
- Control of communicable disease and increase in chronic degenerative diseases.
- Progress in the means of communication and transportation.
- Political obligation of the government to provide comprehensive health care.

- Increasing health awareness.
- Rising standard of living (especially in urban areas) and sociopolitical awareness (especially in semi urban and rural areas) with the result that people expect better services and facilities in health care institutions.
- Control and promotion of quality of care by statutory and professional associations
- Increase in specialization where need for team approach to health and disease is now required.
- Rapid advances in medical science and technology.
- Increase in population requiring more number of hospital beds.
- Sophisticated instrumentation, equipment and better diagnostic and therapeutic tools
- Advances in administrative procedures and management techniques.
- Reorientation of the health care delivery system with emphasis on delivery of primary health care.
- Awareness of the community.

1.7.2 HOSPITAL AS A SOCIAL SYSTEM:-

Sociologists have considered hospital as a social system based on bureaucracy, hierarchy and super-ordination-subordination. A hospital manifests characteristics of a bureaucratic organization with dual lines of authority, viz. Administrative and professional. In teaching hospital and in some others, many professionals at the lower and middle level (interns, junior resident, senior residents, and register) are transitory, while as in others, all medical professionals are permanent with tenured positions and nontransferable jobs. There are different types of perspectives, which are followed under social system.

1. Client-oriented perspective, which is that of access to service, use of service, quality of care, maintenance of client autonomy and dignity, responsiveness to client needs, wishes and freedom of choice.

2 . Provider-oriented perspective that of the physician, nurses and other professionals working for the hospital, and include freedom of professional judgment and activities, traditions and terms of practice and maintenance of professional norms.

3 . Organization-oriented perspective which covers cost control, control of quality, efficiency, ability to attract clients, ability to attract employee and staff, and mobilisation of community support.

4 . Collective oriented perspective which includes proper allocation of resources among competing needs, political representation, representation of interests affected by the organization, and coordination with other agencies.

Table 1.1: Hospital as a system

People	**Communication**
A. Staff	• Between
• Physician	• Physicians and patients
• Nurses	• Physicians and nurses
• Paramedical	• Physicians/nurses and paramedical staff
• Supportive	• Physicians and administrator
B. Patients their attendants and relatives	• Administrative and community
Material	• Administrator and nursing/paramedical staff
• Drugs and chemicals	• Nursing/paramedical staff and patients
• Equipment	
• Diet	
Money	**Decision making in**
• To maintain staff, facilities and procure materials	• Cure: Diagnosis, treatment
	• Care: Creature comforts of patients, diet
	• Procurement of materials in right place at the right time

	Action
	• Putting decisions into practice
	• Balanced mix of communication decision making and action

1.7.3 INTRAMURAL AND EXTRAMURAL FUNCTIONS OF HOSPITAL

The activities of the present day hospital can be divided into two distinct types intramural and extramural. Intramural activities are confined within the walls of the hospital, whereas extramural activities are the services which radiate outside the hospital and to the home environment and community. These functions are set out in table below:

Table 1.2: Intramural and extramural functions of a hospital

Intramural Functions of a Hospital	
1. Restorative	
a. Diagnostic	These comprise the inpatient service involving medical, surgical and other specialties, and special diagnostic procedures.
b. Curative	Treatment of all ailments.
c. Rehabilitative	Physical, mental and social rehabilitation
d. Care of emergencies	Accidents as well as diseases
2.Preventive	
a. Supervision of normal pregnancies and child birth b. Supervision of normal growth and development of children c. Control of communicable diseases d. Prevention of prolonged illness e. Health education f. Occupational health	
3. Education	
a. Medical undergraduates	

b. Specialists and postgraduates c. Nurses and midwives d. Medical social workers e. Paramedical staff f. Community (health education)
4. Research
a. Physical, psychological and social aspects of health and disease b. Clinical medicine c. Hospital practices and administration
Extramural Functions of Hospital
1. Outpatient service 2. Homecare service 3. Outreach service 4. Mobile clinics 5. Day care center 6. Night hospital 7. Medical care camps

The division of hospitals into three categories:-

1. The first group is the “providers” of medical care, viz. the doctors, nurses, technicians and paramedical personnel.

2. The second group is management, administrative and support group comprising of personnel dealing with non clinical functions of the hospitals, such as diet, supplies, maintenance, accounts, housekeeping, water and ward, etc.

3. The third group and the most important one for whose benefit the first two groups exist in the first place, is that of the patients who seek hospital service and their attendants, relatives and associates who, along with patient come in close contact of the hospital. This group is broadly termed as the “community”.

1.7.4 THE CHANGING SCENE IN THE HOSPITAL FIELD

The technical abilities have outstripped our social, economic and political policies. The technological advances in the field of medical sciences have provided clinicians with more esoteric aids to diagnose and treat illnesses. Clinics and communities will continue to pressure hospital management to provide such advances even though they will be very costly. Not only pressures will increase for providing newer technological capabilities, but there will be growing demands for such care. There are growing indications that this has started happening in our Indian situation.

Since treatment is provided free of charge in government hospitals, it has in many cases resulted abuse, particularly in the outpatient department. This has led to the patient being made to pay a small charge, varying between 10 to 20 recent of the cost of medical attention, which, though modest is a useful contribution to hospital running costs.

The model of the nationalized health system that took shape in Great Britain and some other countries has not found true acceptance in India, because health and medical care is not a central but state subject. Allocation of funds for the health sector both in the central and state budgets has also declined gradually. Perhaps this is the reason, among others, that private institutions, commercial firms and corporate bodies are jumping into the medical care field to form investor-owned, for profit hospitals.

One third of the last decade's increase in medical costs is attributed to increase use of high technology medicine particularly surgical and diagnostic procedures. Even then, successful launching of state of the art investor owned hospitals has proved that hospitals can benefit from corporate management principles and can function profitably and efficiently without sacrificing quality and affordability.

At the turn of the century most people died at home cheaply. Today, more than 20 percent die in expensively equipped hospitals, and it is estimated that up to half of an average person's lifetime medical expenses will occur during his last six months.

The changing trends are indicating the following:

- In determining the extent and coverage, there will be more and more dominance by consumers rather than providers or producers.
- Hospitals and health care institutions will become akin to industries.
- Not all services under one roof. Hospitals will be catering more and more to the needs of patients in fragments, which:

1. Will lead to more and more specialized hospitals in place of general hospitals which provided medical, surgical, obstetric and gynecological, ENT, pediatrics, etc. under one roof.
2. People will shop for medical care.
3. Hospital will require more and more management skills as administrators at each level.
4. Will lead to growth of corporate hospitals and modern management concepts.
5. Will be capital intensive.
6. Will be technology intensive.
7. Ascendancy of technical expectations over human values.

1.7.5 URBAN HOSPITAL CONCENTRATION

More and more doctors are concentrating in larger cities; as a result the quality of service which the outlying communities get has remained mediocre. The government and health care services are increasingly dependent upon young doctors to provide medical care services through measures promoting two or three year's rural service in peripheral hospitals and primary health care centres. This is not a pleasing arrangement for rural people who have constant changes of their doctor, and the later regards his or her stay as a temporary one with no future to it in the rural health centre/hospital.

The teaching of medicine and medical research play a decisive role and has therefore a great influence on hospital planning. Today, specialized training comprises a very large part of medical curriculum, and a student spends more and more time in the specialist departments. The people's perception of teaching hospitals as centres for highly

specialized treatments and excellence has tended patients to concentrate in urban centres with medical colleges.

Sickness insurance

The charitable nature of hospital of the past has given way to the principle of the universality where every social class is admitted. The introduction of sicknesss-insurance and social security schemes, although not on universal scale has contributed to this. The economic structure in India has not yet permitted large scale application of this principle, but the hospital system has to take stock of this emerging development.

1.7.6 PREVENTIVE MEDICINE, HEALTH PROMOTION AND HOSPITALS

The scope of medical examination and treatment is being extended to take care of the post-sickness conditions and the importance of rehabilitation of sick and disabled people is being emphasized. The scope of medicine is also expanding to include “pre-sick” conditions of human beings. In this context, the example of the so-called “ningen dock” in Japan, which performs complete physical check –up of apparently healthy people is illustrative. The term “ningen dock” is a olloquial Japanese term meaning examination in dock, comparing to a ship’s dock wherein a ship is thoroughly inspected on completion of long voyage. Ordinary people can undergo a complete physical check-up at such facilities during a period of three to seven days once every year or two, be hospitalized and receive early treatment if any disease condition is discovered, and can receive proper guidance and instruction on their physical condition. Most general hospitals in Japan have beds specially reserved for this “ningen dock” programme.

Priorities in the developing countries should be of preventive nature, whereas modern medical technology strives to lessen the effects of disease, to defer incapacity or death. The organization of preventive medicine and the hospital system have developed independently along dual lines. The fusion of preventive medicine activities and the hospital has not yet emerged. But as medicine has both a preventive and curative purpose, ideally hospital facilities should meet both these ends. In making available the resources of specialized establishments for prevention on one hand and inpatient care and treatment

on the other, the multipurpose centre, combined and coordinated with other health activities, represent the best service available (B.M. Sakharkar, 2003).

1.8 HEALTH EXPENDITURE IN INDIA

Health expenditure is a planned expenditure of Government of India, public percentage of gross domestic product (% of GDP) in India was 1.20 as of 2011. Its highest value over the past 16 years was 1.20 in 2012, while its lowest value was 0.94 in 2005. Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.

Health expenditure, private percentage of gross domestic product (% of GDP) in India was 2.67 as of 2011. Its highest value over the past 16 years was 3.56 in 2004, while its lowest value was 2.67 in 2011. Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations, and direct service payments by private corporations.

Table 1.3: Percentage of GDP on Health Expenditure

	Public		Private	
Sr. No.	Year	% of GDP	Year	% of GDP
1	1995	2.97	1995	1.04
2	1996	2.89	1996	1.00
3	1997	3.18	1997	1.07
4	1998	3.19	1998	1.10
5	1999	2.91	1999	1.13
6	2000	3.16	2000	1.11
7	2001	3.43	2001	1.07
8	2002	3.38	2002	1.02
9	2003	3.32	2003	0.98
10	2004	3.56	2004	0.94
11	2005	3.31	2005	0.94
12	2006	3.08	2006	0.94
13	2007	2.92	2007	0.96
14	2008	2.90	2008	1.03

15	2009	2.86	2009	1.09
16	2010	2.69	2010	1.06
17	2011	2.67	2011	1.20
18			2012	1.30

Source: World Health Organization National Health Account database

Table 1.4 portrays that in developed countries health care expenditure is steadily increasing but in India health care expenditure increases then decreases, in 2012 it was same as 1995. However, public health expenditure has been grossly inadequate right from the 1940s. The government has been spending less than private expenditures on health. The Bhore Committee report stated that per capita private expenditure on health was Rs. 2.50 compared to a state per capita health expenditure of just Rs. 0.36 which is 1/7th of private expenditures. In the 1950s and 1960s private health expenditure was 83 per cent and 88 per cent of total health expenditure respectively (Ravi Duggal, 1995). Today also according to latest figures the proportion of public expenditure on health to GDP in India is only 0.9 per cent of GDP while the average public spending of less-developed countries is 2.8 per cent of GDP. Only 17 per cent of all health expenditure in India is borne by the government, the rest being borne privately by the people, making it one of the most highly privatised healthcare systems of the world (Human Development Report 2003).

Table1.4: Comparison with some emerging and developed economies:

S. No	Country name	Year																	
		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
1	China	3.5	3.8	4.0	4.4	4.5	4.6	4.6	4.8	4.8	4.7	4.7	4.6	4.4	4.6	5.1	5.0	5.1	5.4
2	Brazil	6.7	6.8	6.8	6.7	7.1	7.2	7.3	7.2	7.0	7.1	8.2	8.5	8.5	8.3	8.8	9.0	8.9	9.3
3	UK	6.8	6.8	6.6	6.6	6.9	7.0	7.3	7.6	7.8	8.0	8.3	8.4	8.5	9.0	9.9	9.6	9.4	9.4
4	US	13.6	13.6	13.5	13.5	13.5	13.6	14.2	15.1	15.6	15.7	15.8	15.9	16.1	16.5	17.7	17.7	17.7	17.9
5	Russia	5.4	5.6	7.1	6.6	5.8	5.4	5.7	6.0	5.6	5.2	5.2	5.3	5.4	5.1	6.2	6.3	6.1	6.3
6	France	10.4	10.4	10.3	10.1	10.2	10.1	10.2	10.6	10.8	11.0	11.0	11.0	10.9	11.0	11.7	11.7	11.6	11.7
7	India	4.0	3.9	4.2	4.3	4.0	4.3	4.5	4.4	4.3	4.5	4.2	4.0	3.9	3.9	3.9	3.7	3.9	4.0

Source: World Health Organization National Health Account database

Within India also we see that there is huge gap in different states in economic terms and also in terms of development of health sector. Ahluwalia (2000) in his article raises this issue while analyzing the performance of individual states. The paper states, “The economic performance of the individual states in post-reforms period has received less attention than it deserves in the public debate on economic policy. There is very lively debate in the academic world and in the press on our national economic performance and the success or failure of various aspects of national policies, but there is relatively little analysis of how individual states have performed over time and the role of state government policy in determining state level performance.” We examine the state level public health expenditure.

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