EARLIER STUDIES ON HOSPITAL MANAGEMENT: A REVIEW
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CHAPTER II

EARLIER STUDIES ON HOSPITAL MANAGEMENT:
A REVIEW

2.1 INTERNATIONAL STUDIES ON HOSPITAL MANAGEMENT

Though studies on the financial aspects of government hospitals and their break-up, hospital waste management, quality control and hospital management systems are available in plenty, only few studies have been undertaken from human resource perspective in the private sector. Even international studies talk basically about restructuring, cost analysis and quality assessment in hospitals.

The 1992 Vol. (a) of International Labor Organization (ILO) has very specifically mentioned about the absence of published studies in the field of health. “In many countries until recently, there has been little interesting employment practices in the health sector and this is reflected in the absence of published studies in this field.”

One of the criticisms about research on hospital performance as reported by Elizabeth West in ‘Management matters: the link between hospital organization and quality of patient care’ is that “it has been rather insular, paying little attention to developments in the related fields such as Organizational Sociology, Organizational Behaviour, Management Studies, or Human Resource Management. Most of these disciplines study organizational performance in the context of a market and their dependent variables are usually profitability, productivity or market share.”
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The resolutions drafted by Ashtekar started with the following note: “India belongs to the bottom layer of the Human Development Index (HDI) in the world. Within the country, barring Kerala and Goa, most states show poor health indicators.”

In a country where services are centralised, with an imbalance in personnel and low staff motivation and poor standards of care, there will be a resistance to any new reform. There has been a decline in the standards of service between 1986 and 1997. Poor financial and human resources policies and management are resulting in high cost and poor quality of care. A recent study concluded: "Human resources should become the central focus for reform".

World Bank has provided a clear understanding to every country on health and its importance. It has also criticized the approach of various governments on public health. “A population’s health contributes to its well-being directly, because health is necessary to the enjoyment of life, and indirectly, because healthy workers are more productive. Because people appreciate both the consumption value and the production value of their own health, even poor households spend surprisingly large amount of their own resources for healthcare, and people lobby their governments to provide subsidized healthcare. Yet analyses of health sector spending in poor countries find that governments typically spend too little money on health with too little result.”

The same point of lack of government support for healthcare has been reiterated through Richard G.A. Feachem’s study which says, “In Asia, and especially in India, health care is mainly purchased ‘out of pocket’ from private doctors and clinics. In many African countries, the proportion of finance and provision that is
private is rising due to the reality and the perception (which has lagged behind the reality) of the inability or unwillingness of governments to pay for and provide even basic health services to the majority of the population. The governments of low-income and middle-income countries, together with the international agencies and the health policy community, have neglected or ignored this reality over the past decades. It can no longer be avoided.⁶

But, in the meeting on the follow-up of World Health Assembly Resolution WHA 48.8 and the recommendations of the Ministerial Consultation on Medical Education and Health Services it was reported that “Health personnel generally account for 60–70% of total ministry of health budgets.”⁷

Jishnu Das and Jaffrey Hammer, in their article in Journal of Development Economics, explain public sector spending on healthcare and the items under which the money is distributed. “The public sector spends more than 80% of the government’s health budget on salaries for doctors and heavy subsidies to educate them.”⁸

Research and Consultancy Outsourcing Services, that offers complete business reports about various industries, have envisaged a major growth in healthcare. Their November 2006 report states “Healthcare industry is the world’s largest industry with total revenues of approximately US$ 2.8 Trillion (2005).”⁹

William Glasser (1972), while comparing hospitals in different countries, comments that “Medical institutions cannot originate without a market. Anthropological evidences suggest that recognition of physical and emotional problems by potential patients is universal among the world’s population, whether he
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is a western city dweller or a peasant in an underdeveloped country. The human being is aware of discomfort and inability to perform his normal social roles. However, the decision to take practical action and the choice of remedies vary widely according to the social system and the individual status in each social system.¹⁰

The report on discussion at the Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms at Geneva in 1998 declared that “Health services are usually seen as ‘essential services’ and so health workers have the legal status of public servants. They are accountable to employers and professional bodies and subject to strict regulation and registration rules. Nowadays, the public health sector is changing from being a public service to one with a greater commercial focus. The same Health Assembly adopted a resolution (resolution WHA 48.8) urging the World Health Organization (WHO) and its member states to undertake coordinated reform in health care, focusing on making better use of resources, especially human resources. This recommendation applies not only to the utilization of health care workers but also to their education and training.”¹¹

Stephen Bech in his article “Labour and social dimensions of privatization and restructuring: Healthcare Services”, asserts various issues of human resource management in private hospitals. Some of the excerpts on the topic which he submitted to the International Labour Officer are as follows:

“...the health sector has evolved a complex division of labour with a high degree of specialization. In response to the budgetary constraints and the difficulties of recruiting certain types of occupational groups, managers are reorganizing and...”
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reform in healthcare, focusing on making better use of resources, especially human resources. This recommendation applied not only to the utilization of healthcare workers, but also to their education and training.\textsuperscript{13}

Saltman and von Otter (1995) in their article, “Implementing planned markets in healthcare: Balancing social and economic responsibility”, explains that, “It is probably no exaggeration to claim that flexibility in the use of labour and in payment system is one of the most sought after effects of the entire health reform process”. \textsuperscript{14}

Berman Peter in his article, ‘Health sector reform: making health development sustainable’ considers health sector reform and its impact on Human Resources for Health (HRH) in developing countries and countries in transition. Health sector reform has been defined as the “sustained purposeful change to improve the efficiency, equity and effectiveness of the health sector”. Health sector reform involves many fundamental changes to the way in which public services are financed, organised and delivered in both the developing and the developed countries, and often operates as part of a wider programme of public sector reform. Fiscal reform, the introduction of market mechanisms and decentralisation are the three key elements of health sector reform.\textsuperscript{15}

Jane Lethbridge, in her publication on human resources for health entitled, ‘Public Sector reform and demand for human resources for health’, stated, “Although health sector reform has included elements of human resources strategies such as improved education and training, restructured salary scales and a closer link between performance and reward, it has also had a fundamental impact on organisational
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culture and public sector ethos, which, in turn, influence demand for human resources.  

The quality of medical services depends on the competence of providers, the incentives for them to show up for work, and the allocation of resources within clinics.

Abel Smith, B. (1983), is of the opinion that “In-patient care seemed to consume just under half of all the expenditure on health services. In the USA and Sweden it was higher – about 45% but generally, most of the current hospital expenditure is for staff”.

A study of four countries in Eastern and Southern Africa by Mogedal S. and Steen S.H. concluded that "human resource development, personnel management and staff motivation are critical issues. Tanzania, although it has invested in human resource development, found that low salaries, delayed promotion opportunities and poor working conditions led to dissatisfaction in the workforce. Staff performance has been found to be unsatisfactory. Although monetary and non-monetary allowances were supposed to compensate for low wages, they have led to poor teamwork and lack of continuity in health service operations".

While studying the influence of health sector reform and external assistance Burkina Faso, Bodart C., Servais G., Mohamed Y.L. and Schmidt B. reported, “In a country where services are centralised, with an imbalance in personnel and low staff motivation and poor standards of care, there is resistance to the new reform. There has been a decline in standards of service between 1986 and 1997. Poor financial and
human resources policies and management are resulting in high cost and poor quality of care. Human resources should become the central focus for reform.²⁰

Studies by Peter I. Buerhans forecasted a significant shortage of registered nurses over the next 10 years; because anywhere in the globe the number of nurses leaving the labour market will exceed the number of new entrants, thereby resulting in demand outpacing supply.²¹

Franco L.M., Bennett S. and Kanfer R., in their study on public sector health workers’ motivation, reiterate that “Low pay also contributes to low administrative capacity, as well as poor organisational discipline. In an analysis of health worker motivation, health sector reform was found to influence health worker motivation through changing organisational structures and community-client roles. Organisational factors influence worker motivation through management structures, communication processes, organisational support structures, processes, and ways of providing feedback about organisational and individual performance”.²²

On the basis of the study conducted by Alwan A. and Hornby P., it has been proved beyond doubt that “the working conditions of health workers need to be improved. This might be achieved through developing more flexible employment arrangements that are employee-focussed. The public sector needs to be encouraged to establish a "living wage" and other forms of worker security, so that terms and conditions of public sector workers are better than those of private sector workers. Health workers need to have access to continuous professional development that includes skills for performance management, management of contracts and other new ways of operating in reformed systems”.²³
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Peter Bernam (1986), in his article on cost analysis as a management tool for improving the efficiency of primary care, gives some examples from Java and Indonesia, showing as to how the inefficiencies in staffing patterns, personnel management and drug management can affect cost efficiency. He found that routine analysis of cost data could provide the basis for management incentives to local health units to increase both output and quality of care.24

According to Brito, Galin and Novick, “In the public institutions that remain, market conditions have been introduced and services are contracted out, which has resulted in a widespread decrease in job security in many countries. Health workers have moved from collective-bargaining arrangements to individual contracts. Decentralisation and privatisation have contributed to the breakdown of national collective bargaining. In Eastern and Central Europe, new organisations and professional associations and reorganised trade unions have led to a breakdown in labour relations expertise.25

Wheelan Susan’s study on teamwork and patient’s outcome in intensive care units brings links between teamwork and positive outcomes that have been established in a number of fields. Investigations of a similar nature in healthcare yielded equivocal results. Staff members of units with mortality rates that were lower than predicted, perceived their teams as functioning at higher stages of group development. They perceived their team members as less dependent and more trusting than did staff members of units with mortality rates that were higher than predicted. Staff members of high performing units also perceived their teams as more structured and organized than did staff members of lower performing units.
The study tends to support the contention that, while motivation and commitment remained high, morale among nursing staff was often low. The reasons varied, but included heavy workloads, exacerbated in some instances by staff shortages and the amount of change taking place. A frequent complaint made by staff is about a lack of promotion opportunities, or doing work out of grade because of reducing the numbers of high-end graded posts.

While different methods of working, new technology, etc., lead to greater productivity, it also leads to increased staff workloads. Staff said that they were caring for more patients with fewer staff; that many staff had to cover up absences with no extra resource; and that there was often an unnecessarily long gap between a post becoming vacant and it being filled. There were concerns that quality of treatment was suffering and a fear that reducing manpower may finance future pay awards. Long working hours and heavy workloads contribute work place stress and ill health. Many times even over time have exceeded statutory regulations.

Organisational factors influence worker motivation through management structures and processes, communication processes, organizational support structures and processes, and ways of providing feedback about organizational and individual performance. These changes in organizational culture have often had a negative impact on workers' motivation. Important informal factors, for example staff commitment, have 'become the prime means of direction, motivation, coordination and control'. When staff commitment deteriorates over time, health workers may migrate, not only from public sector to private sector but even
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Internationally, this results in the shortage of skilled health workers within the public sector, precipitating in the growing demand for skilled health workers. Del Favero A. and Barro G. comment on Italian Health Market as “These managers are usually not medically trained and this may create tensions with the medical staff who feel threatened by the increasing power of managers. Doctors fear that their professional autonomy is being undermined as a budgetary logic overrides the needs of patient care. This process has been particularly marked in countries, which have introduced forms of managed competition. In the UK, general managers were introduced in the mid-1980s. These managers on short-term contracts linked to performance-related pay had strong incentives to meet their budgetary targets. The 1990 reforms, which introduced competition between hospitals, have strengthened further the position of managers to the dismay of the nursing and medical professions. In Italy, the 1995 health reforms introduced elements of managed competition and decentralized authority more to hospital level, reinforcing the position of hospital managers.”

Himalayan Times, a daily of Nepal, states in detail a few hospital regulations they propose in the article ‘Nepal hospital regulations: Can we have an update?’ In July 2002 the Nepal Government announced plans to regulate health services to be made effective from January 2003. This was announced at a workshop organised by the Ministry of Health in Kathmandu on ‘Review of criteria for private health institutions in Nepal’. The guidelines laid down include the following:

(i) Medical Professionals would not be allowed to work at more than two institutions. (ii) Private hospitals and nursing homes would have to provide facilities
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for emergency, outpatient and surgery services, among others. (iii) Hospitals with over 100 beds would have to have a blood bank. (iv) Charges against the hospital / doctor would be determined by a committee formed by the government. (v) Hospitals to conform to salary standards set by government.29

Gary Starzynski comments on a survey, which was conducted on 19 Central New England Laboratories, that some hospitals had positions available, but unfilled because it was difficult to find qualified personnel. Most hospitals said technical employees stay at their institutions for two to five years. Salary considerations were the leading reason given for employee departures, but few laboratory managers anticipated major changes in their salary structure over the next five years. Overtime was cited as the chief method of coping with staffing shortages. On asked as to why technical workers stay on the job longer than clerical workers, they said, ‘Perhaps they feel a stronger need to gain more experience before moving on.’

When the participants were asked to identify the four most common reasons that Medical Technicians and Medical Lab Technicians leave the profession, more than three-quarters cited money (salary dissatisfaction or an opportunity to earn more). Stress or burnout and hours were also factors, according to two-thirds of the respondents. Eight respondents (44 per cent) mentioned frustration with the profession; only seven (39 per cent) mentioned fear of AIDS and other communicable diseases.30

Polidano, in his article, “The New Public Management in Developing Countries – in Public Policy and Management” suggests that, low pay levels have led
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to staff leaving the public sector and moving to the private sector, NGOs and aid agencies.31

Low pay also contributes to low administrative capacity, as well as poor organisational discipline. In an analysis of health worker motivation, health sector reform was found to influence health worker motivation through changing organisational structures and community-client roles. Organisational factors influence worker motivation through management structures and processes, communication processes, organisational support structures and processes, and ways of providing feedback about organisational and individual performance.32

Studies on nurse burnout and magnet hospitals [Magnet status is an award given by the American Nurses’ Credentialing Center (ANCC), an affiliate of the American Nurses Association, to hospitals that satisfy a set of criteria designed to measure the strength and quality of nursing.] in the United States concluded that professional development, cooperation with medical staff and managerial support were highly important for nurses.33

These changes in organisational culture have often had a negative impact on workers' motivation. Important informal factors – for example, staff commitment – have "become the prime means of direction, motivation, coordination and control". When staff commitment deteriorates over time, health workers may migrate, not only from the public sector to the private sector, but internationally. This results in a shortage of skilled health workers within the public sector, precipitating a growing demand for skilled health workers. 34
The working conditions of health workers need to be improved. This might be achieved through developing more flexible employment arrangements that are employee-focused. The public sector needs to be encouraged to establish a "living wage" and other forms of worker security so that terms and conditions of public sector workers are better than those of private sector workers. Health workers need to have access to continuous professional development that includes skills for performance management, management of contracts and other new ways of operating in reformed systems.

Barnsley, Louise et al. in their article, 'Integrating learning into integrated delivery systems' tries to promote the fact that thorough learning and flexible hospital personnel would be better prepared to face the challenges imposed by a complex and competitive environment. The integration of learning into these systems requires a shared vision, facilitative leadership, and highly functioning communication channels within an organic structure. Strategies that promote positive attitudes toward change are necessary for learning as is the provision of resources, training, incentives, and rewards that support learning, and feedback on how new administrative and clinical practices advance the mission and goals of the system.

Therefore, hospital resource information system must be set up. The system's first challenge would be to create a "climate" that encourages people from diverse parts of the system to interact in ways that develop common understandings and trust.

McGourty, Tarshis, and Dominick describe several integrative management practices that contribute to an innovative culture by encouraging collaborative behaviour, informal relationships, constructive conflict, cross-functional
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communication, and open communication with external sources. These practices include: "(a) employee rewards and recognition; (b) employee development; and (c) multifunctional teams. Reward programs that link performance reviews and decisions on career progression and promotions to successful learning reinforce the value that the system places on the generation of new knowledge and insights. Knowledge acquisition and transfer can be supported through employee development activities, such as on-the-job training, job rotation, and training programs that emphasize teamwork, interpersonal skills, idea generation techniques, and management of the innovation process. New ideas can be stimulated by encouraging the regular review and debate of ideas and by making discretionary funds available for experimentation. Finally, multifunctional teams can be used to bring together a variety of specialists and customers in order to generate a broad knowledge base for the cross-fertilization of ideas."

Education and training programs can be powerful tools for transferring knowledge and skills across system components if they are linked explicitly to use. Employees who have opportunities to practise what they have learned, and whose posttraining performance is monitored, are the most likely to master new knowledge and skills.

Integrating information technology (IT) into medical settings is considered essential for transforming hospitals into 21st century health care institutions. An article reported a 3-round Delphi panel that tried to analyse problem that personnel experienced with electronic data systems. In round 1, 35 administrative, clinical, and IT personnel answered 10 open-ended questions about IT strategies and structures that
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best support successful transformation. Four domains emerged from round 1: IT organization, IT performance monitoring, user-support activities and core IT responsibilities (e.g., computer security, training).

Performance monitoring and clinical support activities were rated as the most important, and organization and core IT responsibilities were rated as relatively less important.40

Even when a study was conducted in Australia to identify the factors affecting job stress and job satisfaction of Australian nurses it was identified that a significant challenge facing the healthcare sector was the recruitment and retention of nurses. The job stress and job satisfaction of nurses have been associated with recruitment and retention. The aim of this study by Timothy and Theresa was to consider two factors that may contribute to the job satisfaction and job stress of nurses: social support and empowerment. Using a sample of 157 registered nurses in a private hospital in Melbourne, Australia, they found that “social support derived from the nurses supervisor and work colleagues lowered job stress and at the same time increased job satisfaction. The presence of nurse empowerment, meaning, impact, competence and self-determination, also lowered job stress and increased job satisfaction.”41
2.2 STUDIES ON HOSPITAL MANAGEMENT IN INDIA

Modern society has developed formal institutions for patient care. The hospital, a major social institution, offers considerable advantages to both the patients and the society. A number of health problems require intensive medical treatment and personal care, which normally cannot be available in a patient’s home or in the clinic of a doctor. This is possible only in a hospital where large number of professionally and technically skilled people apply their knowledge and skill with the help of world class expertise, advanced sophisticated equipments and appliances. 

Most of the studies in India too have been about managing finance or the social issues related to health. In Health, Poverty and Development in India (Das, Chen and Krishnan) the authors have mentioned about the health statistics and poverty ratios of developing India. Social issues have been focussed in the article ‘Social Intermediation and Health Changes: Lessons from Kerala’ (Kabir M. & Krishnan T.N.) and in ‘Historical Analysis of the Development of Health Care Facilities in Kerala State’ (Kutty V.R.), where the authors try to explain the revolutions happening in the health sector. Ramachandran V.K has also analyzed Kerala’s health in his article ‘On Kerala’s Development Achievements - Selected Regional Perspectives’. Over and above these social perspectives a few financial perspectives can also be seen as in ‘Managing Money of Hospitals’ (Jangaiah P.). Again studies on quality has made its presence, thanks to the multidimensional, generic, internationally used market research instrument called SERVQUAL (Parasuram et al., 1988). The human resource aspects have been studied only on a limited scale, even though we have huge medical professionals.
While inaugurating an eleven-day seminar on 'Hospital Management' in the All India Institute of Medical Sciences, Dr. S.S. Sidhu, the then Secretary, Ministry of Health and Family Welfare, admitted:

Management was the weakest aspect of Indian hospitals and called for their management by professionally trained personnel, especially because a hospital is a labour-intensive organization and employs a very large number of people. Such a labour-intensive organization needs a highly proficient management. He reiterated that modern hospitals need not only highly qualified medical specialists, para-medical and nursing officers but also personnel managers, finance officers, cost accountants, housekeeping officers, linen and laundry officers, food service managers, maintenance managers, security officers, etc. He further said that apart from the rising population which has increased the pressure on hospitals, society has now accepted the hospital as a healthcare institution and is utilizing it more frequently, often for even minor ailments. The ever rising demand increases the need for proper management of hospitals.52

Studies by the Central Bureau of Health Intelligence show the following: majority of Indians trust private healthcare even though its average cost is more than US$4.3 and the government–owned healthcare agencies cost only US$2.7. It has further been estimated that while 59 per cent of healthcare expenditure originated from the ‘self-paid’ category, less than 30 per cent is contributed by the states. The study also reports 'limited government investment provides significant opportunities for private healthcare service providers as large investments are required to scale up the country's healthcare infrastructure. The government is likely to meet only 15-20
per cent investment in hospital beds, assuming it increases expenditures by 6-7 per cent from the current base. Assuming 10-15 per cent commitment from international donors, there would be a shortfall of 70 per cent, which would definitely be funded by private companies.53

"At a time when the expenditure requirements on health are rising, the State is finding it increasingly difficult to meet these requirements. In fact, the quality of services in the Government health services has declined for want of enough funds.

Consequently, there has been an increase in the demand for private medical care services offered very often on commercial terms. "This, in turn, has boosted the average private expenditure on medical care. The State seems to be losing its gains on the health front," K.K George, Director of Centre for Socio-Economic Research said.54

According to the study by IBEF, on the Indian Healthcare sector, "The Indian healthcare sector has been growing at a frenetic pace in the past few years. The windfall began ever since the developed world discovered that it could get quality service for less than half the price.

India will spend US$ 45.76 billion on healthcare in the next five years as the country, on an economic upsurge, is witnessing changes in its demographic profile accompanied with lifestyle diseases and increasing medical expenses, says a CII-Mckinsey study on 'Health in India'. Revenues from the healthcare sector account for 5.2 per cent of the GDP and it employs over 4 million people. By 2012, revenues can reach 6.5 to 7.2 per cent of GDP and direct and indirect employment can double, it said.
Private healthcare will continue to be the largest component in 2012 and is likely to double to US$ 35.7 billion. Other estimates suggest that by 2012, healthcare spending could contribute 8 per cent of GDP and employ around 9 million people.

From a pan-India perspective, presently there are more than half a million doctors employed in 15,097 hospitals. Additionally there are 0.75 million nurses, who look after more than 870,000 hospital beds. During the previous decade, the number of doctors has increased by 36.6 per cent. An estimated 30 per cent of medical practitioners hold specialist qualifications.

Soumya Viswanathan (2002), in her article on Outsourcing in Healthcare Management, opines that "Employee per bed ratio can be kept optimum, provided effective utilisation of manpower is done by creating multi-skilled and multi-tasked personnel. In a typical hospital set up, expenditure on salary amounts to roughly 25-30 per cent of total income or 30-35 per cent of total expenditure. This is not healthy statistics, say experts. Most hospitals are believed to operate with excess manpower. As competition increases and margins come under pressure, hospitals tomorrow will have no option but to rationalise manpower, which, in other words, would mean downsizing."

Ravi Duggal (2000), in a symposium on the state of our Public Health System, stated, "Today there are over 15,000 hospitals (68% private) with about 900,000 hospital beds (45% private), about 25,000 primary health centers in the country, and a total of over 12,00,000 qualified practitioners (89% private) of all systems of medicine. The skewed rural/urban availability of public health services is well known – 70% hospitals and 85% of hospital beds under the public domain are located in
urban/metropolitan areas, while 70% of the population lives in the rural and backward areas of the country.

The pattern of distribution of the private health services is not very different. They too tend to concentrate in urban/metropolitan areas – 60% of hospitals, 75% of hospital beds and 70% of allopathic doctors are found in urban areas. However, the private health sector is not confined just to quality allopathic practitioners. There are nearly twice as many practitioners qualified in various Indian systems of medicine and homoeopathy, and a larger proportion of them (60%) are located in the rural and backward areas, 90% of them also practising modern medicine.

Over the last nine Five-year plan periods the Planning Commission, or for that matter, the Ministry of Health have not paid much heed to the way in which the private health sector has grown and operated. In fact, the state has subsidised the growth of the private health sector by various means – subsidised medical education even for those who ultimately go into private practice or, worse still, migrate abroad; concessions, subsidies and tax relief to private practitioners and hospitals. Many private hospitals function as trust hospitals whose incomes are exempt from income tax. Public sector units have supplied bulk drugs and raw materials at subsidised prices to the private pharmaceutical industry and have in the process earned the label of ‘being in the red’ and ‘inefficient’. Import duty concessions for expensive new medical technology which largely benefits the richer sections have also been provided". 57
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A Study of Hyderabad and Chennai hospitals by Rama V. Baru, Brijesh Purohit and David Daniel (1999) states "We feel privatisation has influenced the perception and practice of the medical professional." 58

Rita Dutta (2003), in her article ‘Nurses come and nurses go, but hospitals learn to survive’, mentions about the exodus of nurses. ‘Today when patient satisfaction is accorded supreme importance with the healthcare sector functioning like any other service industry, one of the thrust areas of a hospital is good nursing care. However, providing good nursing care today poses the biggest challenge with hospitals grappling with the alarming exodus of nurses.

On an average a private hospital in a metropolis witnesses an annual exodus of around 50 nurses, with some hospitals even facing an outflow of over 80 nurses, annually. Hospital administrators complain that no sooner a fresh nursing student learns the ropes of her job she is lured away by the lucre in hospitals abroad. The domino effect is that a lot of constructive time of nursing administration goes away in screening new candidates to fill up the vacancy’. 59

Wilfred A. D’Souza (1982), Minister of Health, Goa, Daman & Diu spoke on training for medical professionals as extremely important since obsolescence in this area is very quick. The health workers have to constantly update their skills, knowledge and attitudes. 60

B.S. Aggarwal in his article, ‘Hospital Profits Depend on its Relation with the Doctor’, stresses on the material benefits a hospital can earn by maintaining a good relationship with the doctors. He says, “If the doctors are happy they would
recommend the hospital facilities to a large number of patients and consequently a profitable hospital is established.

In his opinion, doctors should be awarded bonuses out of hospital profits. The bonus should be on performance basis. This currently creates loyalty to the hospital project and a sense of belonging comes in all doctors when they get his or her due share.

A teamwork is more appropriate to establish a good rapport with the public and it promotes the good functioning of a speciality. Moreover a good teamwork is essential to run the hospital emergency turn by turn or unit by unit.

The nursing and other staff are migratory birds and one can stop them only through good payment for good work while keeping the minimum commitment notes for their probation period and experience gained.  

'Service quality in Bangalore hospitals – an empirical study' was conducted by R.Rohini and B.Mahadevappa, to identify five dimensions of service quality, the most important being, assurance of quality of nursing care in five major hospitals in Bangalore. It was brought to the notice of the researchers that most of the in-patients were extremely happy to the excellent nursing care, assistance in the reception, neat and clean house keeping facility, very cordial and empathetic staff, ever-smiling and ever-ready helpers and the attitudes of the physicians who would listen to their queries sympathetically.

Gajendra Singh et.al., had identified customer satisfaction as one of the critical success factors in his article 'Potential of healthcare industry in India'.
N.V. Ramamurthy’s article proposes certain suggestions to Nursing Schools and Colleges. Entitled, ‘Training the Angels’ he comments that “Manpower drain to developed economies is a constant worry and, in the case of nurses, especially of late, this should not be taken lightly. The industry has to find ways and means of retaining talent and not remain content with the claim that a populous country will always provide cheap manpower. Quality of healthcare does suffer in the long run. The industry should invest in setting up reputed nursing colleges primarily for domestic requirements and later for overseas demand, if required, but experienced staff must be given their due in this country first.”

Rues Ajita Pawar, Nursing Superintendent, Nanavati hospital, Mumbai, states, “Nursing is a skilled job which requires training. The various courses in nursing sadly do not give an understanding of clinical care. It is only during the job that they learn. But by the time they gain experience, it is good bye time for them.”

C. M. Francis (1998) opines that “Health is labour intensive and an area where trained manpower is most critical. If the health care is to improve it is necessary that a concerted effort be made to make available the right kind of personnel in the right number at the right places. Problems of inadequate numbers, improper training and unequal distribution have to be solved.”

Following are the resolutions adopted and reiterated in the Council Meeting of Trained Nurses Association of India (TNAI), (2003) on “Recruitment of nurses on contract with less salary”,
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- Whereas it is observed that nurses are recruited on contractual basis on lesser salary in many Government and private hospitals, which is not in keeping with the human rights of equality.

- Whereas it is observed that there is no uniformity in pay scales of nurses within a particular institution/state, while they perform similar jobs.

- Be it resolved to urge the Central and State Governments, Municipal Corporations and other employing authorities to recruit nurses on regular basis and not on contractual basis.

- Whereas it has been brought to the notice of the Trained Nurses' Association of India, that there are unqualified and unlicensed persons working as nurses in different parts of the country by obtaining false Nursing Certificate through illegal means.

- Whereas it is felt that if these unscrupulous persons are allowed to function without proper scrutiny, the patient care system will be in jeopardy and Whereas the Trained Nurses' Association of India, Indian Nursing Council, State Nursing Councils, Central and the State Governments should take suitable legal action against such persons.

- Be it resolved therefore, that the unqualified and unlicensed persons who are working as nurses in different institutions in various parts of the country by obtaining false certificates should be traced and suitable legal action taken by the authorities concerned.\(^{57}\)
Janpaksh, a revolutionary magazine brings to notice that “After the nurses themselves saw that nothing can be achieved without building pressure upon the Government, they took to strike on 5th May 1998, demanding implementation of new pay package, enhancement in allowances, time bound promotions, proper housing, filling up of vacancies, setting up of Nursing Directorate, non - practising allowance and implementation of 1997 agreement.

Nurses have learnt the valuable lesson that whatever concessions the working people can get, they can get only through their united and concerted efforts and only by taking to the path of struggle. Nobody is going to pay heed to their plight, unless and until the working people themselves do not rise up against the conditions of their life and once the working people rise to change these unjust conditions, no power on this earth would be able to prevent them from achieving their common goal i.e. Liberation of the working people.”

Another magazine, Amar Jesani, also wrote about nurses in the private sector as “ Interestingly, most nurses’ strikes have been in the government sector, though in India the private sector holds an estimated three-fourth of hospitals and beds. The private sector must employ at least as many nurses as the government does, if not more. And their condition is much worse.”

Hindustan Times Bureau reported in September 2003 on Code of Ethics for hospitals in Andhra Pradesh, “Private nursing homes and hospitals in Hyderabad will now have to follow a Code of Ethics requiring them to standardise their rates, make their billing transparent, counsel patients and follow clear procedures for diagnosis and treatment. The code is to be followed by all the 450 institutions registered under
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the Andhra Pradesh Private Hospitals and Nursing Homes Association’s Hyderabad and Rangareddy district branch.70

Ms. Saritha Varma in her article in the Financial Express stated, "At Rs 11.54, the fund-strapped Kerala exchequer's spending per patient is also the highest in the country. However, a recent study by A Raman Kutty has observed that although the state's inputs in health care have not fallen, 98 per cent of this went to feed establishment costs, like wages. However, over 20 million poor patients in taluk hospitals and medical college wards still go without beds, medicines and care."71

Francis P.A., comments in his article, 'An Excellent Legislation', about the revolutionary legislation which could bring regulatory control on private hospitals, nursing homes and other healthcare establishments. He comments “The private sector plays a crucial role in the healthcare sector of this country today as most of the state governments have failed to set up adequate number of hospitals and primary health centres. The mushrooming growth of private medical facilities in states, therefore, is only a natural outcome of the states' neglect of this social responsibility. Most of the states do not even have proper records of the number of private medical facilities operating. A large majority of these private medical establishments do not follow any standards of services as there are no specific regulations to govern them. They, therefore, indulge in several unethical practices and charge exorbitant fee for the substandard services.”72

On commenting on recruitment of different categories of staff in JNM Hospital, Cochin, Dr. P.K.Purayakastha, Chief Medical Officer, Fertilizers and
Chemicals Travancore Ltd., Kerala said “written job assignment is served to the concerned employee within 4 weeks of order of appointment.”

He suggests that the following broad general principles should, therefore, be kept in view in organizing the health services of tomorrow:

- The training of the health services personnel should be fully oriented to the people – their social, cultural and economic conditions and their health profile.

- The health services should be pyramidically organized – with a large base in primary healthcare and a narrow top in the specialized and highly specialized institutions.

- The preventive, promotive and curative problems should be defined accurately at each level, right from the village to the sub-center, community, district, State and Central levels. This should be on the basis of actual studies and not on assumptions as at present.

- The skills, services and facilities required for each level must be defined on the basis of the above findings.

- The selection of personnel and their training should be on the basis of the requirements for the specific jobs they have to perform. The education level for the selection of candidates must be adequate and not excessive. Over-education is often counter-productive.

- Selection at the lower levels should be of persons from within the local community itself.
• The service conditions should be properly defined and more equitable than at present. There should be adequate avenues for promotion of all workers on the basis of ability and motivation. Transfers should not be misused, as is often done at present, for purposes of punishment or harassment.

• Training should be as close to workers as possible. It should be job specific, decentralized, efficient and economic.73

Indian Journal of Medical Ethics (Oct-Dec 2004) reports, “Nurses’ abysmal wages and working conditions have not been affected by the many national level committees on the subject”.74

Rita Dutta,75 reports in The Indian Express, that “The exodus is markedly low, if not non-existent, in the corporate hospitals because of better salary and training. Wockhardt Hospitals Group, for instance, does not witness less than five nurses leaving their hospital, annually. Vishal Bali, Vice President, Wockhardt Hospitals Group, states that they are able to retain their nurses as they offer better salary and training on par with international standards.

Saritha Vanna reported in Financial Express that “Vacant posts in government hospitals are not being filled up and the nurse-patient ratio is pretty skewed, says a nursing college staff. In general wards of government hospitals it should be 1:6. “But it goes up to 1:30. And then patients expect nurses to be pleasant and smiling. Is it possible?” she asks. Nurses therefore prefer private hospitals even though they pay less — a stop-gap arrangement before they go abroad.”76

Ravi Duggal, health researcher and activist stated, “The spread of private clinics and hospitals must be regulated through a strict locational policy, wherein the
local authority is given the right to determine the number of doctors or hospital beds they need in their area (norms for family practice, practitioner : population and bed ratio, population ratios, fiscal incentives for remote and under served areas and strong disincentives and higher taxes for urban and over served areas etc., can be used).

Duggal, also suggested that Continuing Medical Education (CME) should become compulsory and linked to renewal of registration. Graduates passing out of public medical schools must put in compulsory public service of at least five years, of which three years must be at PHCs and rural hospitals. This should be assured not through bonds or payments, but by providing only a provisional licence to do supervised practice in state health care institutions and also by giving the right to pursue postgraduate studies to only those who have completed their three years of rural medical service". 77

Varadarajan in his article in Journal of Health & Population in Developing Countries has compared health status of Kerala with Tamil Nadu. He states, “Although Tamil Nadu is comparable with Kerala in terms of several human development indicators (some experts even predict that the State might overtake Kerala in about 20 years or so from now), ‘Kerala model of development’ still remains unique and it is difficult to replicate it elsewhere. The similarity between Tamil Nadu and Kerala ends with their achievements in the fields of health and education. Otherwise, there are a lot of dissimilarities between them including the paths chosen by the two States to achieve what they achieved so far. High literacy, equitable development, strong political system, healthy life style and a well functioning public (Allopathic and Ayurvedic) health care system have all contributed
to the attainment of good health indicators in Kerala. In contrast, Tamil Nadu had poor literacy, high degree of poverty and inequitable development with serious rural-urban, rich-poor and male-female differences when the health indicators started showing up. But, Tamil Nadu had better economic growth indicators. One factor that was common between the two States was a well functioning public health care system.\textsuperscript{78}

And finally in his address to the members of the Kerala Legislative Assembly, Dr.APJ Abdul Kalam, the President of India, said “Nursing is a core competence of Kerala. India is in the process of improving the healthcare services which will need additional 5 lakh nurses. As per the latest report, worldwide requirement for nurses are estimated to be around one million from now to 2012. Presently, in India about 50,000 nurses qualify every year. There is a need to increase this capacity to 2 lakhs within the next five years in the country. The present contribution of 4,000 nurses from Kerala State should also increase at least 20,000 nurses per year. In addition there must be a special drive to equip the nurses with training at various healthcare centers and super speciality environments and equip them with language skills and proficiencies that can match the required international standards. Kerala can definitely cater to at least 50% of the total demand i.e. provision of one million nurses from now to the year 2012. The Department of Health in Kerala should draw up a scheme and embark on an intensive nursing training scheme in collaboration with the Central Government which will enable generation of quality health care professionals at the rate of 2 lakh nurses per year. In addition, with increasing complexity of healthcare profession with diagnostic equipment, tele-medicine, clinical trials etc. There is a
need for many other specialized paramedical personnel. Skilled technicians and the para medical assistance are in great demand world over in the healthcare sector. The tremendous potential exists for educated youth to take up nursing and para-medics as a profession. The generation of quality nurses can be taken as one of missions for the development of healthcare services in Kerala without sacrificing quality.  

Thus the survey of literature on human resource management issues brought to light the existence of research gaps in studies in the private hospital segment in Kerala. This study is expected to reduce the gap on the various HR issues related to human resource in the private hospital sector of Kerala which basically include (a) a detailed study of the existing human resource management practices and (b) identifying the reasons for the high rate of employee turnover in the private hospitals in Kerala.
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