



Commitment of State Health Officials: Identifying Factors and Scope for Improvement

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Abstract

Commitment, competencies and skills of people working in the health sector has significant impact on sector performance and its reform process. The current paper is a part of broader multi state studies carried out by the authors in India. The paper attempts to analyse the commitment of state health officials and its implications for human resource practices in Gujarat. The study suggests Gujarat, as compared to other states of India, have achieved significant progress in ensuring commitment of its health officials. However, the state needs to invest progressively and in a proactive manner towards improving the leadership quality, supervision skills and autonomy at workplace to improve and sustain the motivation of its health officials. Improving motivation for the health staffs also involves issues related to infrastructure, involvement, supervision and monitoring, continuous medical education and training, human resource planning, smooth reporting process, administration and audit requirements and prioritisation and synchronisation of health programmes. In order to achieve this, two sets of strategies for reforms are suggested. One relates to short term achievable reforms and other relates to long-term research based actions.

Keywords: Commitment, Health Reform, HR Practices

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1. Introduction

Human Resource Management (HRM) issues are very important components for effective implementation of health sector programmes and therefore are important components of sector reform agenda. Availability of adequate funds, equipments and people to man and manage the programmes alone may not necessarily lead to successful implementation of programmes and reforms. The health system in India faces daunting task of meeting health challenges of growing population. These complexities have arisen because of shrinking budgetary support due to fiscal constraints, lower commitment among staffs in health system and lack of coordination and managerial capacity.

Health sector reforms aimed at addressing these deficiencies have focused on making health systems responsive through fostering effective decentralisation, plans based on explicit and agreed policies, developing capacity in the system, local participation and autonomy, emphasis on quality and sustainability and coordination among development partners on policy, strategy and activities. These reforms have intrinsically made some fundamental assumptions:

- high organisational commitment of healthcare providers
- high professional commitment of healthcare providers
- adequate skills of healthcare providers

These are important assumptions, as the success of healthcare reforms will critically depend on their validity. This paper examines the commitment and competencies of doctors working in public health facilities and its implications for health sector reform. The study was carried out among the senior district health officials of Gujarat, one of the progressive states of India.

2. Gujarat

Gujarat with a population of 50.6 million (2001 census) and density of 258 persons per sq. km. has emerged as a major healthcare destination in western India. Proximity to markets, good purchasing power, availability of resources, good infrastructure and an official vision towards growth of entrepreneurship are some of the factors that have enabled Gujarat to achieve high growth. Gujarat stands second (after Kerala) among 15 major states of India with respect to density of hospitals and dispensaries. Gujarat has about 123 doctors per 100,000 persons and 143 beds per 100,000 persons. With support from European Commission, the state has implemented health sector reform programme since 2000. An overview of the vital statistics of the state is provided in Annexure 1.

3. Commitment and its Construct

Commitment is a multidimensional contextual construct. Organisational commitment refers to employee's loyalty to the organisation, their willingness to work on behalf of the organisation, degree of their goal and value congruency with the organisation and their desire to maintain membership (Bhat and Maheshwari 2005; Porter, Crampon, and Smith 1976; Porter, Steers, Mowday and Boulian 1974). Professional commitment refers to one's loyalty to the profession and the willingness to strive and uphold the values and goals of the profession. Professionals like doctors may do well to provide healthcare out of their concern for the profession alone.

Allen and Meyer (1990) have proposed a three-component model of organisational commitment: affective, normative and continuance. The affective component of organisational commitment refers to employees' emotional attachment to identify and involve with the organisation. The

continuance component refers to employee's commitment based on the costs that they associate with leaving the organisation. The normative component refers to employees' feeling of obligation to remain with the organisation. Affective, continuance and normative commitment are viewed as distinguishable components, rather than types of commitment; that employees can experience in varying degrees. Meyer and Allen (1991) argue that common to these approaches is the view that commitment is a psychological state that characterises the employee's relationship with the organisation, and has implications for decisions to continue or discontinue membership of the organisation.

Commitment leads intrinsic desire among employees to contribute better output to improved services; it also reduces the need for external monitoring mechanisms. Committed employees need less supervision to control their behaviour. In health sector, employees are expected to strengthen organisation's image among customers through cooperative behaviour. The literature on organisational commitment portrays employees with high organisational commitment not only as highly productive (Mowday, Lyman and Robert 1974) and satisfied but also highly responsible with high civic virtue (Nico, Agnes and Martin 1999). All these are important prerequisites to ensure provision of adequate quality of healthcare services.

4. Role of Human Resource Practices in Organisation Commitment

Human resource management (HRM) practices such as socialisation, hiring policies, career-oriented performance management, open job posting and job transfer practices play critical roles in building employee commitment. Through socialisation processes managers can attempt to foster better employee understanding of organisational values, norms and objectives (Pascale 1985; Maanen and Schein 1979), leading to employees' identification with the organisation (Jones 1986). Similarly, factors such as confirmation of pre-entry expectations (Arnold and Feldman 1982; Premack and Wanous 1985) and role clarity (Morris and Koch 1979) are important at the time of hiring employees to enhance organisational commitment.

Performance appraisals that enhance job clarity (Maheshwari, Bhat and Saha 2005) and involve people in the process (Brown and Robert 1994) enhance organisational commitment. Additionally, the purpose of the appraisal process also influences organisational commitment. Appraisal, aimed at developing people, is more likely to induce organisational commitment.

According to social exchange theory, perceived investment in employees' development is positively associated with the affective commitment of the employees (Lee and Brouvold 2003). On the other hand, training improves the employability of employees, and thus, when proper career advancement or opportunities to use the learned skills are not provided; there are higher chances that employees may quit. Promotion and internal recruitment policies help employees to grow from within. This elicits a sense of belongingness among employees, and thus, commitment – both emotionally and morally.

5. Research Questions

Consistent with the literature review and our earlier experiences with the health officials of India's other major states (Bhat and Maheshwari 2005; Maheshwari, Bhat and Saha 2005), criticality of commitment, competencies and HR practices for reforming the healthcare sector, this paper examines the commitment of district level health officials in the state of Maharashtra in India and its relationship with other HR practices.

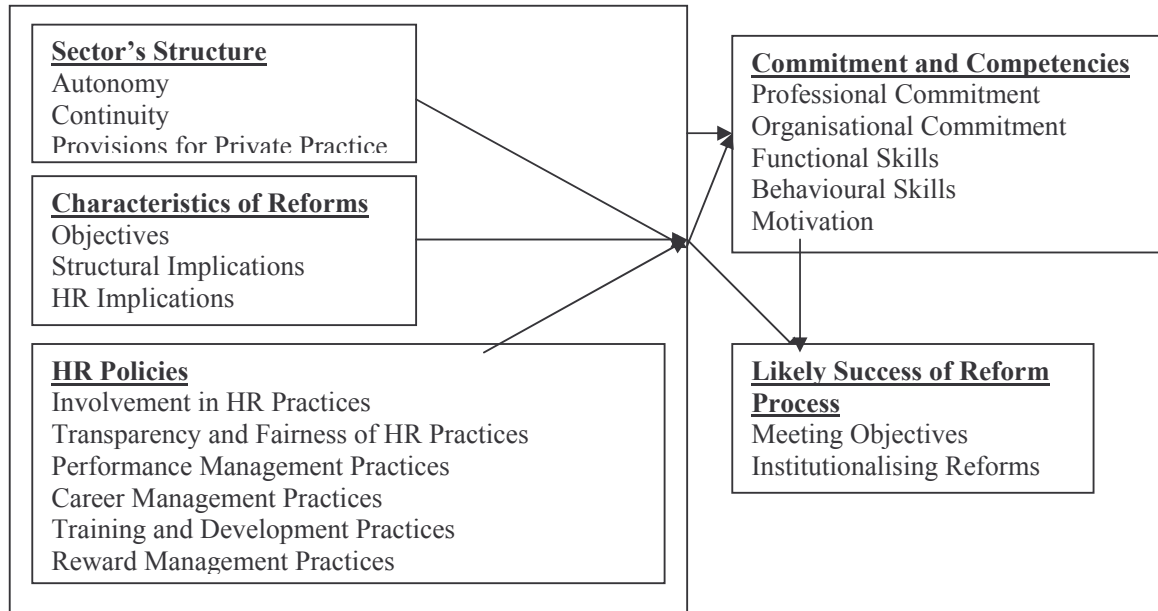
Accordingly, the problem statements were as the following:

- What is the status of professional commitment, organisational commitment and technical competencies of health officials in the State?
- What are the characteristics of human resource management practices in the health sector in the State?

- How are these management practices linked with professional and organisational commitment?

Answers to these questions are critical in designing and implementing health sector reforms. The model shown in Figure 1 was used for the study. Commitment scales were developed based on three dimensions: affective, normative and continuance (Meyers and Allen 1991).

Figure 1: Model for the Study



The study, conducted at a management institute based in western India, aimed at exploring HR practices in the State and their implications for commitment of health officials. The aim was to understand the factors affecting the work environment of officials in the health system. To measure commitment and its relationship with HR practice variables, a self-administered questionnaire was used. It was based on the one developed by Bhat and Maheshwari (2005), and tested among the health officials of Maharashtra, Chattisgarh and Madhya Pradesh. The questionnaire was specifically designed to measure the commitment and HR practices of senior officials of health system.

Respondents reported data in two parts. Part A of questionnaire asked questions about their personal and organizational details. Age, qualification, work experience, gender, number of organizations worked in the past are the main personal detail items. Age and experience items were measured in number of years, educational qualification is categorized in five (1 to 5) categories. Part B of the questionnaire contained 83 items measuring the human resource practices in the respondents' organization, and respondent's OC. The items were measured on a five-point Likert scale. A Likert scale measures the extent to which a person agrees or disagrees with the question. It varies from strongly disagree to strongly agree. Principal Component Analysis (PCA) with varimax rotation was conducted across all HR variables to identify underlying factors. Items with factor loadings > 0.50 only were considered for grouping, while items with loading < 0.50 and/or with cross loadings > 0.35 were dropped. The above criteria extracted thirty five factors (Eigen value > 1) measured by 63 items, and including almost all the theoretically defined constructs. PCA validated the scale because the extracted factors conformed to the theoretical grouping of items under each group. While the scales for the questionnaire were developed to measure professional and organisational commitment, technical competencies were measured through professional affiliations of doctors in the state.

Sample Characteristics

The study was conducted among two groups. The first group comprised of health officials at district and state level. It provided the strength of allowing us to study at the strategic level at the top and most crucial operational level: district. The second part captured the responses of medical officers posted in interior health centres of Gujarat.

Thirty Two district and state health officials agreed to participate in the study. The working areas of the officials are: 4 from directorate, 12 from district hospitals and 13 from other hospitals. Hence, it is likely to be a true representation of the state of HR practices in the state of Gujarat. Their experience in department and age averaged 18.27 years and 46.03 years. Experience in medical profession averaged 19.79 years.

Twenty three Medical Officers from interior health centres of Gujarat participated in the study. The working areas of these officers are: 8 from Block Health Office (BHO); 12 from Primary Health Centre (PHC); and 3 from Community Health Centre (CHC). The discussion represents the cross-section views of medical officers working below district level. Their experience in department and age averaged 10.54 years and 37.87 years. Experience in medical profession averaged 11.13 years. The characteristics of the sample and mean of different dimensions are provided in Annexure 2.

9. Findings: Commitment

The professional commitment of the doctors and the State officials is found to be higher than organizational commitment (Table 1). It shows that the organizational commitment of doctors and state health officials is on the lower side. The higher commitment to their profession drives doctors to execute their professional responsibilities even if their commitment to their departments is lower. The affective organisational commitment for health officials in Gujarat is 3.61. This, and normative commitment (3.54) indicate that district health officials share fairly strong emotional bond with their department.

	Mean (Scale: 5.0)	N	Std. Deviation
Affective Commitment to the Department	3.61	55	0.46
Affective Commitment to Profession	4.01	54	0.74
Normative Commitment to the Department	3.54	55	0.64
Normative Commitment to Profession	3.81	53	0.69
Continuance Commitment to the Department	3.01	53	0.73
Continuance Commitment to Profession	3.21	53	0.84

In order to identify any difference in commitment level among top level and middle level health officials, we used Kruskal-Wallis test. The Kruskal-Wallis test is a nonparametric alternative to one-way ANOVA. Significance levels below 0.05 indicate that the group locations differ. In the Kruskal-Wallis test, the scores are ranked without regard to group membership. N identifies the distribution of cases across groups. Mean Rank lists the average rank for each group. The result (Table 2) shows that none of the commitment variable differs across groups, suggesting no

marked difference across groups. For a vibrant state like Gujarat looking towards a prosperous health status of its population, this is a good indicator on which the state can base and build up its health plans and programme

Table 2
Difference in Commitment Level as per Mean Rank and Level of Significance

	Group	N	Mean Rank	Chi-square	Df	Asymp. Sig.
Affective Commitment to Department	Senior Health Officials	32	26.20	0.98	1	0.32
	Medical Officers at Grass Root Level	23	30.50			
	Total	55				
Normative Commitment to Department	Senior Health Officials	32	24.61	3.47	1	0.06
	Medical Officers at Grass Root Level	23	32.72			
	Total	55				
Continuance Commitment to Department	Senior Health Officials	32	25.16	1.16	1	0.28
	Medical Officers at Grass Root Level	21	29.81			
	Total	53				
Affective Commitment to Profession	Senior Health Officials	31	25.34	1.46	1	0.23
	Medical Officers at Grass Root Level	23	30.41			
	Total	54				
Normative Commitment to Profession	Senior Health Officials	30	24.98	1.22	1	0.27
	Medical Officers at Grass Root Level	23	29.63			
	Total	53				
Continuance Commitment to Profession	Senior Health Officials	31	25.65	0.58	1	0.44
	Medical Officers at Grass Root Level	22	28.91			
	Total	53				

For reform process in the health sector to succeed, state should promote high involvement of its doctors. Involvement of health officials are intrinsically linked to their commitment towards the system. Commitment, as discussed, comprised of three important dimensions – affective, normative and continuance. To understand the actions that significantly affect organisational commitment, a regression analysis was done. The regression equation of commitment with HR practice variables provided the results given in Table 3.

Do HR practices affect Commitment?

Western literatures have talked extensively about effect of human resource (HR) management practices in building employee commitment (Refer to section 4). However, the result of regression equations (Table 3) does not point to a strong association between HR practice variables and commitment. Small value of adjusted R square indicates that only a small proportion of variance in the dependent variable is explained by the regression model. This led us to further investigate the question Do HR practices really affect commitment? We attempt to answer the question through conducting a workshop with the respondents. The findings suggest a strong impact of leadership and supervision quality on commitment of individuals. Gujarat being

one of the progressive states of India in terms of road and infrastructure development; doctors are not particularly upset with accessibility and remoteness of work place. This is in sharp contrast to our findings from other states of India. The Department of Health and Family Welfare can bank upon this development, and invest in developing leadership, autonomy and supervision skills of the medical officers. Medical officers are particularly upset about low autonomy in the department with regard to reward and recognition, accounting procedure, prioritisation and synchronisation of health programme and other administrative activities.

Table 3	
Dependent Variable: Affective Organisational Commitment (Adjusted R square = 0.45)	Standardised coefficient
Constant	
Consultation in Posting	0.56*
Importance of Financial Return	-0.37*
Dependent Variable: Normative Organisational Commitment (Adjusted R square = 0.60)	
Constant	
Importance of financial return	-0.64*
Role in Training of Subordinates	0.42*
Dependent Variable: Continuance Commitment to Department (Adjusted R square = 0.59)	
Constant	
Concern towards hours of work	-0.40*
Importance of job security	0.67*
Concern for Fringe Benefit	-0.52*
Job Clarity	-0.037*

* Statistically significant at 5 per cent level.

Our similar study of health officials of Madhya Pradesh (Maheshwari, Bhat and Saha 2005), suggested that doctors do not want a bureaucratic pattern of staffing decisions. They do not expect postings and transfer to be strictly according to rules. They prefer decisions that are situation-specific, considering skills and other such subjective factors. The department has to examine its decision making to make it more organic than bureaucratic.

Professional skills

Professional qualifications of senior doctors in the state are high. More than three-fourth of the doctors are postgraduates with specialisation in different fields. This is likely to have contributed to their professional commitment. However, the doctors often suffer from lack of autonomy in decision making. Qualitative response from the health professionals substantiated the hypothesis. Such practices lead to erosion of professional competencies of the health officials. Growth of professional competencies is found to be positively related to intrinsic desire among doctors for assuming higher responsibilities and work-role.

10. Findings: Status of Human Resource Practices

Although commitment of health officials were not observed to be directly influenced by HR practices in the health system, the HR practice variables continue to play an important role in building up motivation in the work environment. In order to understand the perception of health officials towards the HR practices in the system, the questionnaire solicited information on key HR practice variables. The results are presented below:

Staffing in health sector

The most striking feature of staffing is the high desire (score: 4.25) among health officials for consultation in planning (Table 8). They want to be consulted whenever an employee is posted in their department. However, the intensity of consultation is substantially low (2.66 in human

resource planning). Similarly health officials view unfair practices and lack of transparency in selection process and staffing decisions (score: 2.80). Interestingly, this findings were strikingly similar among other states studied, namely, Maharashtra, Chattisgarh and Madhya Pradesh (Bhat and Maheshwari 2005; Maheshwari, Bhat and Saha 2005).

Table 8
Staffing Practices

Staffing Practices	Mean (Scale: 5.00)	Std. Deviation
Consultation in planning	2.66	1.10
Importance of consultation in planning	4.25	0.76
Fairness in transfer	2.80	1.17
Transparency in selection	2.97	0.73
Fairness in staffing decision	2.92	0.65

Participation in human resource planning and staffing develops a sense of understanding and belongingness. The department can secure commitment of their staff by involving them in human resource planning. Similar responses were echoed in the qualitative section of the study.

Human Resource Position

A review of human resource position in the state health system of Gujarat reveals (Annexure 3) that the state ranks among the largest number of vacant position in India. Only Madhya Pradesh and Rajasthan ranks above Gujarat in terms of shortfall in human resource position of PHC doctors. Vacancy in health position is sure to affect commitment of health officials because unless the sanctioned positions does not get filled, this is going to put pressure on the existing staffs and irrespective of interventions in human resource practices, the result will not be substantial.

Professional Growth and Career Development

With presence of top class management institutions in Gujarat, effort of European Commission towards health sector reform and presence of a vibrant and proactive state government, the state has been a forerunner in providing a better work environment to its health officials. Health officials view good opportunities for career growth (score: 3.21) and support for growth and development (score 3.19) (Table 9).

Table 9
Career Management and Professional Growth Practices

Career Management Practices	Mean (Scale: 5.00)	Std. Deviation
Opportunities for CME	3.21	0.87
Support for growth and development	3.19	0.70
Seniority based promotion	2.55	0.77
Professional competency development	3.25	0.78
Linkage to seniority based promotion	3.42	1.06

However in spite of investment in career development, doctors do not perceive greater fairness in the system on promotion (score: 2.55) and are of the view that the system still follow seniority based promotion (score: linkage to seniority based promotion 3.42). The results are similar to our findings from Maharashtra study (Maheshwari, Bhat and Saha 2005) and opposite to our findings in Chattisgarh and Madhya Pradesh (Bhat and Maheshwari 2005). The result gives an interesting insight towards effect of proactive state machinery to the perception of its health system officials.

11. Role Construct and Factors Affecting Motivation

In order to assess and identify the need for initiative that State Directorate of Health Services may consider for enhancing the motivation and working conditions of Medical Officers (MO) posted in PHCs and other health service delivery institutions a one-day workshop was organised with the medical officers. The purpose was to identifying roles of the MO at various level of health system; identify factors determining role effectiveness of MO and address issues demanding priority attention in the reform process.

The Role (as perceived by the medical officers)

MOs in the health system perform three sets of activities:

- Clinical activities. The medical officers perceive this to be their primary activity.
- Administrative activities: The medical officers perceive this to be of secondary importance. However, they believe that administrative activities are consuming excessive time. They were critical of the time consumed in MIS. This is because they themselves do not use any of the reports generated. Nor do they see this being used at any level. The management decision making at various levels is not based on data and reports generated.
- Preventive care: They believe it to be important part of their role.

Determinants of Effective Role Execution: The medical officers highlighted three important sets of determinants for effective role execution.

A. Infrastructure

In motivation literature infrastructure related issues are defined as hygiene factors of motivation. The absence of these factors makes the motivational factors ineffective. However, the presence of these factors does not ensure motivation of people. Following hygiene factors were highlighted by the doctors.

- Building for the workplace with inadequate water and electricity facilities
- Communication facilities (telephone) at the workplace not functioning
- Transport facilities for official work not available
- Housing for the staff at the workstation not available
- Sanitation facilities at the workplace not in useable condition
- Educational facilities for children are not available

It was pointed out that most of facilities which were not in good condition were demolished for reconstruction. In most places the reconstruction has been left half-way for long period of time and currently deliveries and other services are being provided in open.

B. Administration

- Fairness and transparency in postings, promotions and assigning training programmes. It is again a strong hygiene factor.
- Availability of amended administrative rule book not available to many doctors.
- Prompt payment of dues like charge allowance etc.
- Training on administrative matters.

C. Setting Priorities in Health Programmes

Acceptability and commitment to the organizational priorities is a strong motivational factor. In this context, the participants raised the following issues:

- There is no prioritisation of various programmes.
- No attempt has been made to rationalise the work and activities and involvement of medical officers in clinical, administrative and other non-clinical activities

D. Reporting and Supervision

This is one of the important motivational factors. The MOs highlighted following issues in this context:

- Inadequacy of facilitating supervision and monitoring
- Lack of continuity of monitoring and supervision
- No use of MIS for monitoring and supervision

E. Human Resource Management

It is an important sensitive issue that influences motivation significantly. The MOs raised the following issues:

- Lack of autonomy in planning for human resource requirements in their facility.
- No system of autonomy or lack of process of involving officers in reward and punishment of staff at the facility.
- No authority to hire staff for some of the essential services like cleanliness of the workplace.
- No involvements in training need analysis.

Improving motivation of MOs at PHCs and other interior health facilities

The dimension for improving motivation and work environment of the medical officers are

A. Infrastructure

- MOs suggested provision for properly constructed clinics and staff quarters. Officers want availability of infrastructure and facilities for the staff which include instruments, housing, building, transportation, vehicles, finance for petty expenses to manage the health unit, communication facilities etc. Under health sector reform initiative, the state has undertaken the task for up gradation of infrastructure including PHC and Sub Centre building, service quarter etc. This works have been delayed for long time without proper reasons. The renovation programme of were started with enthusiasm. The buildings were taken over and breaking of parts of buildings for renovation was done quickly. However, the construction and maintenance after that has not been done at many places for more than 9-10 months. It is creating serious difficulties at many workplaces. The incomplete work is creating difficulties in the field. The water supply and sanitation in several buildings were not properly worked out. In some case there is no water or sewerage line in buildings constructed under this project.
- Often in rural areas, telephone lines are not functional for long time. Such problems need to be fixed in order to ensure proper working environment.
- As per norms, sub-centres are to be located in the centre of village to ensure accessibility. However, in practice, sub-centres are often located at inaccessible places outside the villages. This creates social security problems for the staff and visitors. Sub-centres should be properly located in the villages
- Proper transportation facilities for health staffs and patients will ensure timely service delivery. There is a strong demand to make fuel budget suitable to the current market inflation and not as per age old standards. Each time the revision in this budget has been done in absolute terms. The revision should be done after taking into account the inflation rate.
- MOs are looking for appropriate facilities for the education of their children in cities while they stay in villages.

B. Involvement and Motivation

- Reward and recognition to employees should be according to performance. They were willing to contribute in this effort. This essentially requires review of Performance Management System of the department.
- Determination of protocol for punishment and appreciation to the staffs.

C. Supervision and monitoring

- The department could develop guidelines and checklist for monitoring visits of the facilities. Monitoring visits are often done for the sake of fulfilling administrative requirements.
- Medical Officers believe that department lacks adequate systems of supervision. They wished improved supervision and monitoring that included set guidelines and mechanism for feedback to the facility staffs. Often in health system, there are multiple people giving multiple orders.
- Adequate mechanism for feedback could be developed to enable the facilities to perform efficiently
- There are lot of duplication and unnecessary reporting in health system. Reports are available in different forms. The purpose of data collection and reporting must be explained to Medical Officers.

D. Continuous Medical Education and Training

- Medical officers are often required to handle post-mortem and other medico-legal cases which require specialised training. In order to handle such specialised cases, they should be given adequate in-service training in the field of forensic science.
- Trainings in health system are often not coherent. Different trainers speak in different tunes. There is a demand to provide crisp and quality training to the health staffs.
- Induction training should be provided for MOs.

E. Human Resource Planning

- Human resources should be planned to avoid over burdening of staffs. As per norms, PHCs in rural areas have only one service Medical Officer and he is expected to handle emergencies on 24 hours basis.
- Medical officers are of the consensus that staffs on contract basis perform better than the routine staffs. Hence, there is a demand to hire all class 4 employees on daily basis. However, there is also a feeling to give some sense of security for better performing contractual staffs during renewal of their contracts.
- In health system, about 30 to 50 per cent of the posts are vacant. This creates pressure on the existing staffs.
- Often problems in reporting of health system lies in under-qualified male and female workers. There is a need to raise the qualification of ANMs and MPWs.
- Medical officers are best suited to assess the training needs and identify skills expected from the staff. Hence any training of the paramedic and administrative staffs should be done in their consultation.
- Reward and punishment for the staffs are great incentive for building up motivation among service staffs. Autonomy at facility level will help the Medical Officers in dealing adequately with their subordinates.
- Medical officers feel the need to have the authority in hiring of clinical and non-clinical staffs on a contractual basis.

F. Reporting Process

- Reporting process in health system has a lot of grey area. There are wide duplication and unnecessary reporting in the system. Same reports are asked repeatedly. Data is reported

in so many forms, that it takes 2-3 days to prepare the reports. 60 per cent of time in the staffs gets absorbed in preparing different reports.

- There is inadequate decision and feedback system on the reports generated in the system. There should be adequate system to provide feedback on the reports.

G. Administrative and Audit Requirements

- Financial power of medical officers should be increased beyond the current authorization of Rs. 500. There is a demand for financial authorities at the block level. The current centralised system is creating delay in clearance of financial bills.
- Administrative and audit requirements should be made more simple, fair and transparent.

H. Prioritisation and Synchronisation of Health Programme

- Multiple programmes exist in health system. Some programmes are crash programme and others are routine programmes. There is a need to differentiate routine and regular programme like family planning, blindness control programme, pulse polio programmes and crash health programme like school health programme which must be on routine basis. Often the facility do not have budget to provide medicines required for school health programme, yet the Medical Officers are required to participate in such programmes.
- Health staffs should not be involved unnecessarily in politically influenced programmes and non-medical activities for examples attending monthly meetings of gram sabhas.
- Medical Officers should not be asked to participate in non-medical activities and political programmes like involvement in Krishi Mahostav, Rath Yatra, Panchayat which leads to the hampering of the medical practices.

12. Implications

The commitment, competencies and skills of people working in the health system has significant implications for any sector reform process. This study suggests that although Gujarat has invested in a large way in its health system development, the sector faces a number of challenges to ensure the professional and organisational commitment of officials. Meeting the healthcare needs of the population goes beyond mere budget allocations. The state has to invest in developing leadership quality, supervision skills and developing autonomy in its public health institutions. Along with making public health institutions responsive to local governance, the department has to also give autonomy to its medical officers in prioritisation and synchronisation of health programmes. The reform process in the state health system has to also help in developing strategies that ensure effectiveness and efficiency of resource use. We suggest strategies for reforms should be divided into two parts: Short term achievable reforms and long-term research based actions.

The short term achievable objectives may relate to filling up vacant position through contractual workers, regular and quality training (practical and not theoretical) for health officials, provision for timely disbursement of allowances and salaries, increasing purchasing power for Medical Officers, POL allowance in terms of litres and should take into account rising oil price, fasten work under sector reform programme for repair and renovation of PHC and SC buildings and reduce requirements of Medical Officers to participate in unnecessary rallies and politically motivated programmes.

The long-term research based action will demand significant policy decisions and weighing for the benefits and risk of such actions. We summarise this as autonomy to punish and reward the staff, assess and work out proper locations for building and infrastructure for the health facilities, regular and sufficient grant under proper heads with provision for cross utilization under untied

funds, raise minimum basic qualification for health staffs at grass-root level and rationalise and simplified reporting formats.

Gujarat, as compared to other states of India, has achieved significant progress in ensuring commitment of its health officials. However, the state needs to invest progressively and in a proactive manner towards improving the motivation of its health officials.

*Annexure 1***Profile of Gujarat¹**

Gujarat state came into existence as a separate State on 1st May 1960. The State is bounded by the Arabian Sea in the West, by the States of Rajasthan in the North and North-East, by Madhya Pradesh in the East and by Maharashtra in the South and South East. The State has a long coastline of about 1600 km and is the longest among all States of country. For the purpose of administration, Gujarat State at present comprises of 25 districts, sub-divided into 226 talukas, having 18618 villages and 242 towns. Gujarat has geographical area of 1.96 lakh sq. kms. and accounts for 6.19 per cent of the total area of the country. According to the provisional results of Population Census 2001, the population of Gujarat as on 1st March 2001, stood at 5.06 crore. The decadal growth rate of the decade 1991-2001 has increased in comparison to 1981-1991 from 21.19 percent to 22.48 percent. The density of Gujarat is 258 persons per sq.km. in 2001. According to the provisional results of population census 2001, the total numbers of households were 96.44 lakh. With just 5 per cent of the India's total population and 6 per cent of geographical area, Gujarat contributes to 16 per cent of the country's total investment, 10 per cent of expenditure, 16 per cent of exports and 30 per cent of stock market capitalization. The state's annual growth rate has been 10 to 12 per cent for the last five years. As per the latest data of Centre for Monitoring Indian Economy (CMIE) of January 2003, Gujarat stands first in industrialization in India. Gujarat's State Domestic Product (SDP) is rising at an average growth rate of 12.4% per annum in real terms (from 1994-2002).

Vital statistics of the state are mentioned below.

Key Indicators of the State	
Population (in thousands)	50,671
Males	26,385
Females	24,285
Scheduled Tribes	7,481
Scheduled Castes	3592
Area (in thousand sq. km.)	196
Blocks	225
Districts	25
Literacy rate (Percentage)	69.1
Sex Ratio (Females per thousand males)	920

Source: 2001 census

Vital Health Indicators	
Birth Rate	24.6
Death Rate	7.6
IMR	57.0
TFR	2.8
MMR	540

Source: Sample Registration Survey 2002, 2003

Health Infrastructure (2003)	
Hospitals	59
Dispensaries	41
Primary Health Centres	1027
Beds in Institutions	6648

Source: Compiled from Basic Health Statistics Gujarat 2004-05

¹ Compiled from official portal of Gujarat Government, <http://www.gujaratindia.com>.

Annexure 2
Sample Characteristics

	Mean (Scale: 5.00)	Std. Deviation
AGE	46.03	6.65
EXP_P	19.79	6.40
EXP_D	18.27	7.60
Consultation in posting	2.52	1.11
Job Clarity	3.48	0.89
Training Adequacy	3.24	0.76
Support for Training	3.36	0.58
Role in Training of Subordinates	2.89	0.95
Willingness to Assume Higher Responsibility	3.03	0.62
Freedom in Decision Making	2.63	0.82
Empowerment	4.06	0.52
Relationship with Superiors	3.86	0.65
Importance of Financial Return	2.91	0.55
Concern for Fringe Benefits	2.85	0.85
Pay for Ability	3.06	1.02
Importance of CME	3.71	0.39
Importance of interesting work	3.76	0.78
Concern towards hours of work	3.34	0.90
Expectation towards policies and practices	4.11	0.49
Importance of Job Security	3.48	0.80
Nature of Supervision	3.97	0.58

Annexure 3

State-wise Human Resource Position of Doctors at Primary Health Centre in India (As on September, 2004)					
States/UTs	Required [R]	Sanctioned [S]	In Position [P]	Vacant [S-P]	Shortfall [R-P]
Chhatisgarh	516	873	817	56	*
Gujarat	1070	1070	912	158	158
Madhya Pradesh	1194	1194	947	247	247
Maharashtra	1780	3157	3158	*	*
Punjab	484	484	424	60	60
Rajasthan	1675	1510	1311	199	364
West Bengal	1173	1560	1319	241	*
India	23109	24549	21974	2679	880

State-wise Vacancy Position of Doctors in Primary Health Centres (PHCs), Specialists in Community Health Centres (CHCs) and other Health Staff in Health Institution in India (As on September, 2004)							
States	ANM	MPW(M)	HA(F)/LHV	HA(M)	MO (PHC)	Specialists	Pharmacists
Chhatisgarh	463	611	*	611	56	56	250
Gujarat	624	3016	275	649	158	202	391
Madhya Pradesh	469	748	128	NA	247	NA	NA
Maharashtra	333	1639	279	832	*	888	201
Punjab	315	1175	70	40	60	0	38
Rajasthan	258	1440	10	224	199	223	20
West Bengal	1286	2523	499	946	241	177	207
India	7982	22618	2829	6783	2679	2621	2198

* Surplus

Source: Lok Sabha Unstarred Questions. (Quoted from indiastat website)

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