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Commitment among state health officials & its implications for health sector reform: Lessons from Gujarat

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***Background & objectives*: Commitment, competencies and skills of people working in the health sector can significantly impact the performance and its reform process. In this study we attempted to analyse the commitment of state health officials and its implications for human resource practices in Gujarat.**

***Methods*: A self-administered questionnaire was used to measure commitment and its relationship with human resource (HR) variables. Employee's organizational commitment (OC) and professional commitment (PC) were measured using OC and PC scale. Fifty five medical officers from Gujarat participated in the study.**

***Results*: Professional commitment of doctors (3.21 to 4.01) was found to be higher than their commitment to the organization (3.01 to 3.61). Doctors did not perceive greater fairness in the system on promotion (on the scale of 5, score: 2.55) and were of the view that the system still followed seniority based promotion (score: 3.42). Medical officers were upset about low autonomy in the department with regard to reward and recognition, accounting procedure, prioritization and synchronization of health programme and other administrative activities.**

***Interpretation & conclusions*: Our study provided some support for positive effects of progressive HR practices on OC, specifically on affective and normative OC. Following initiatives were identified to foster a development climate among the health officials: providing opportunities for training, professional competency development, developing healthy relationship between superiors and subordinates, providing useful performance feedback, and recognising and rewarding performance. For reform process in the health sector to succeed, there is a need to promote high involvement of medical officers. There is a need to invest in developing leadership quality, supervision skills and developing autonomy in its public health institutions.**

Key words Commitment - health reform - health sector - HR practices

The health system in India has a daunting task of meeting health challenges of its growing population. The public health sector, over a period of time, has grown in size and scope to address this challenge. The health personnels' behaviour is cited as one of the major causes of poor perceptions about the health care services[1]. Commitment of health personnel has bearing on the quality of services they offer to people.

Organizational commitment refers to employees' loyalty to the organization, their willingness to work on behalf of the organization, degree of their goal and value congruency with the organization and their desire to maintain membership[2,3]. Professional commitment refers to one's loyalty to the profession and the willingness to strive and uphold the values and goals of the profession[4,5].

The literature on organizational commitment portrays employees with high organizational commitment not only as highly productive[4] and satisfied but also highly responsible with high civic virtue[5]. All these are important prerequisites to ensure provision of adequate quality of healthcare services. Employee's professional commitment, on the other hand, refers to employee's loyalty to the profession and willingness to exert effort to uphold the values and goals of the profession, and a willingness to maintain membership in the profession[6,7]. A professional like doctor may do well to provide health care out of their concern for the profession alone[2]. Meyer *et al*[8] extended the three component organizational commitment concept to professional commitment as well. Despite the above conceptualization[8], research on professional form has been scant compared to organizational form. Organizational commitment and professional commitment are closely related but distinct constructs. Meta-analysis by Wallace[9] revealed a positive relation between the two.

Managing human resources (HR) in the health sector is an important component for effective implementation of health programmes and therefore are important components of health sector reform agenda. These are important assumptions because the success of healthcare reforms will critically depend on their validity. We carried out this study to examine the professional and organizational commitment of district and state health officials working in public health facilities in the State of Gujarat, India. Further, we also investigated the effect of human resource policies on their commitment. The following research questions were addressed: *(i)* What is the status of professional and organizational commitment of health officials in the State of Gujarat?; *(ii)* what are the characteristics of human resource management practices in the health sector in the State of Gujarat?; and *(iii)* what are the short- and long-term agendas for reforms in health system of Gujarat to ensure better commitment from the health officials?

Material & Methods

Commitment and its relationship with HR practice variables were measured using a self-administered questionnaire developed by us[2]. The questionnaire was specifically designed to measure the commitment and HR practices of senior officials of health system. Employee's organizational commitment (OC) was measured using a modified version of Allen & Meyer scale[10] adapted to the Indian context. Three forms of OC- affective, normative, and continuance, were measured using seven, seven, and nine item scales respectively. Employee's professional commitment (PC) was measured by adapting OC[10] and PC scales[8] to Indian healthcare context. Three forms of professional commitment-affective, normative, and continuance, were measured using seven, eight, and nine item scales respectively. The HR practices scale was developed based on literature available and responses of healthcare officers in the qualitative study[2]. The items measure the extent of presence of these practices in the respondents' organizations as they perceive it. The HR practices were divided under five groups- human resource planning, career growth, training, performance appraisal, and compensation. The dimensions for the questionnaire were tested in Indian setting, by the authors, through qualitative interview and pilot testing of questionnaire. The reliability of the questionnaire was tested among a selected group of Gujarat State health officials using chronbac alpha. The results indicated high reliability with chronbac alpha score of 0.7 to 0.9 with the commitment items score on the higher side.

The questionnaire was divided into two parts. Part A of questionnaire included questions about their personal and organizational details. Age, qualification, work experience, gender, number of organizations worked in the past were the main personal detail items. Age and experience items were measured in number of years, educational qualification was categorized in five (1 to 5) categories. Part B of the questionnaire contained 83 items measuring the human resource practices in the respondents' organization (of health officials), and respondent's commitment to profession and organization. The items under each group were measured using a five- point (1- strongly disagree to 5- strongly agree) Likert scale[11]. After combining theoretically similar variables, and removing redundant variables, 12 factors were extracted. These factors were tested for unidimensionality and internal consistency.

Part B of the questionnaire relating to the commitment and human resource practices was used as the unit for analysis. Part A of the questionnaire was used to understand the sample characteristics and representation.

At the end of the initial analysis, a one-day workshop with a group of randomly selected 30 medical officers from the sample was conducted to validate the findings from the questionnaire survey.

Sample characteristics: The study was conducted during April 2006, among two groups of health officials in Gujarat. The first group comprised health officials at district and State level. The second part captured the responses of medical officers posted in interior health centres of Gujarat. It provided the strength of allowing to study at the strategic level at the top and most crucial operational level *i.e.*, district.

Thirty two district and State health officials participated in the study. These medical officers were nominated by the State government for one week management training in the State of Gujarat. The working areas of the officials were: 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 Gujarat. Their average experience in the department and age were 18.27 and 46.03 yr respectively. Average experience in medical profession were 19.79 yr (Table I).

Twenty three medical officers, again nominated by the State government, from interior health centres of Gujarat participated in the study. The working areas of these officers included: 8 from Block Health Office (BHO); 12 from Primary Health Centre (PHC); and 3 from Community Health Centre (CHC). The discussion represented the cross-section views of medical officers working below district level. Their average experience in department and age were 10.54 and 37.87 yr respectively. Average experience in medical profession was 11.13 yr.

Table I. Sample characteristics on the scale of 1-5 (n=32)

	Mean	Standard deviation
Age (yr)	46.03	6.65
Experience in profession (yr)	19.79	6.40
Experience in department (yr)	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 continuing medical education	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

Results

The professional commitment of the doctors and the State health officials was found to be higher than organizational commitment (Table II). The higher commitment to their profession drives doctors to execute their professional responsibilities even if their commitment to their departments is lower. The affective organizational 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.

In order to identify any difference in commitment level among top and middle level health officials, Kruskal-Wallis test was used. The results (Table III) showed that none of the commitment variable differed across groups, suggesting no marked difference across groups.

To understand the actions that significantly affect organizational commitment, a regression analysis of commitment with HR practice variables was done.

Result of regression equations (Table IV) did not point to a strong association between HR practice variables and commitment. Small value of adjusted R square indicated that only a small proportion of variance in the dependent variable was explained by the

Table II. Commitment of doctors at district and State level to the department and the profession (Scale: 5.00)

	N	Mean ± SD
Affective commitment to the department	55	3.61 ± 0.46
Affective commitment to profession	54	4.01 ± 0.74
Normative commitment to the department	55	3.54 ± 0.64
Normative commitment to profession	53	3.81 ± 0.69
Continuance commitment to the department	53	3.01 ± 0.73
Continuance commitment to profession	53	3.21 ± 0.84

Table III. Difference in commitment level as per mean rank and level of significance

	Group	N	Mean rank	Chi square	Df	Significance
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				

Table IV. Regression analysis on organizational commitments

	Standardised coefficient
Dependent variable: Affective organizational commitment (Adjusted R square = 0.45)	
Constant	
Consultation in posting	0.56*
Importance of financial return	-0.37*
Dependent variable: Normative organizational 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	-0.37*

*Significant at P=0.05

Table V. Staffing practices among health officials

Staffing practices	Mean (Scale: 5.00)	Standard 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

Table VI. Career management and professional growth practices

Career management practices	Mean (Scale: 5.00)	Standard 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

regression model. This led us to further investigate the question: Do HR practices really affect commitment? We attempted to answer this question through conducting a workshop with the respondents. The findings suggested 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. Medical officers were particularly upset about low autonomy in the department with regard to reward and recognition, accounting

procedure, prioritization and synchronization of health programme and other administrative activities.

A similar study of health officials of Madhya Pradesh[12], suggested that doctors do not want a bureaucratic pattern of staffing decisions.

Professional qualifications of senior doctors in Gujarat were high. More than three-fourth of the doctors were postgraduates with specialization in different fields. This may have contributed to their professional commitment. However, the doctors often felt lack of autonomy in decision making. Qualitative response from the health professionals substantiated the hypothesis.

Although commitment of health officials was not observed to be directly influenced by HR practices in the health system, the HR practice variables continued 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 most striking feature of staffing was the high desire (score: 4.25) among health officials for consultation in planning (Table V). They wanted to be consulted whenever an employee was posted in their department. However, the intensity of consultation was substantially low (2.66 in human resource planning). Similarly health officials viewed unfair practices and lack of transparency in selection process and staffing decisions (score: 2.80). Interestingly, these findings were strikingly similar among other states studied, namely, Maharashtra, Chattisgarh and Madhya Pradesh[2,12].

The State government has been a forerunner in providing a better work environment to its health officials. Health officials viewed good opportunities for career growth (score: 3.21) and support for growth and development (score 3.19) (Table VI).

However, in spite of investment in career development, doctors did not perceive greater fairness in the system on promotion (score: 2.55) and were of the view that the system still followed seniority based promotion (score: linkage to seniority based promotion 3.42).

Discussion

Our study provided some support for positive effects of progressive HR practices on OC, specifically on affective and normative OC. But the HR practices did not have similar effect on professional commitment. Also, progressive HR practices did not affect continuance commitment of either form. Moreover, there was no difference in commitment level among top and middle level health officials. 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.

The results were similar to our findings from Maharashtra study[11] and opposite to our findings in Chattisgarh and Madhya Pradesh[2]. Our results suggest that the State needs to invest in developing leadership, autonomy and supervision skills of the medical officers. Consolidating the regression results for OC, it was clear that the following initiatives may foster a developmental climate which will help doctors/officers in developing and growing professionally: providing opportunities for training, professional competency development, developing healthy relationship between superiors and subordinates, providing useful performance feedback, and recognising and rewarding performance.

An affective organizational commitment score of 3.61 clearly suggested the need to make effort on improving the factors affecting OC. Committed doctors are likely to contribute to the success of reform process. Conversely, the reform processes which enhance these factors are more likely to be accepted by the doctors, and thus are likely to succeed better. Doctors' professional commitment was found to be higher than their organizational commitment, indicating their higher identification with the profession than organization. But the regression results indicated that the HR practices had no major influence on professional commitment. However, good relations with superiors, clarity on job objectives, autonomy on work, *etc.*, could help in delivering responsibilities professionally. Some of the possible actions were related to providing higher responsibilities to doctors and imparting leadership and supervision quality. Doctors were keen to participate in the development plans and staffing decisions for their workplaces. Hence, the health system will have to work towards designing better and transparent administrative practices.

Since HR practices do not exert large influence on professional commitment, higher professional commitment could be the result of good professional skills of the majority of respondents. Most of the senior doctors were postgraduates with specializations in different fields. But the organizational commitment was low, which could be due to inadequate developmental

opportunities, and low score on fairness perception of HR practices. Policy makers should, therefore, provide growth and development opportunities for employees and implement fair and transparent HR practices to effectively implement reforms.

Our data indicate that the health sector was facing a number of challenges to ensure the professional and organizational commitment of its officials. On the positive side, health officials shared a strong emotional bond with their department and medical profession and this was similar across ranks in the health system. While professional commitment of doctors was not affected significantly by human resource practices, their organizational commitments to department were linked with the opportunities to develop themselves professionally on job. For reform process in the health sector to succeed, there is a need to promote high involvement of medical officers. There was a need to invest in developing leadership quality, supervision skills and developing autonomy in its public health institutions.

The commitment, competencies and skills of people working in the health system has significant implications for any sector reform process. Health sector policies and planning need to address the human resource vis-à-vis systems issue in order to make the system responsive to the needs of the community. Our study provided useful and important insight relevant to health sector reform in India and elsewhere. While the study provided the strength of studying the perception of officials working at the strategic level at the top and most crucial operational level district health system in a state, the potential weakness of the study related to response bias among more professionally vulnerable junior level professionals. However, during instrument designing and analysis stage, most of the response bias was taken care of by putting reverse coded items and then checking for consistency in response. The other weakness of the study was limited quantification and judgemental error in relying on qualitative response from the medical officers through a one day workshop to validate the findings. Though this provided critical inputs which provide important direction, further validation of the results is required.

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