Provider’s Constraints and Difficulties in Primary Health Care System

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ABSTRACT

Background: The contractualization of human resource in recent years has resulted into various human resource management issues. Objective: To explore the administrative and management issues of contractual model of human resource under primary health care system in Delhi. Materials and Methods: Comparative study was conducted on randomly selected sample of 333, comprised of Medical Officers, ANMs, Pharmacist and Laboratory Assistants and Technicians, both regular and contractual cadre. The data was collected using the semi-structured interview schedule and thematic content analysis was done. Results: The five major themes emerged in the analysis; these are (i) physical infrastructure, (ii) organization’s working environment, (iii) privileges of staff, (iv) discontentment, (v) human resource development. Comparative analysis of themes between regular and contractual staff revealed significant differences in factors which are embedded into the organization’s culture. Element of discontentment is high amongst contractual staff particularly for discrimination in job, undermining of authority, patient care relationship and privileges provided to regular staff. This reflects the area of dissatisfaction which varies between regular and contractual staff in the organization. Conclusion: If primary health care system fails to address genuine constraints of human resources of both regular and contractual cadre and perception of discrimination persists, it is bound to result into poor motivation for good performance in the system of health care. So, adopting good practices in human resource management keeping regular and contractual employees grievances at forefront are urgently needed to ensure the availability of adequately trained and motivated personnel’s in health facilities.

Keywords: Conflict, contractual staff, human resource, motivation, privileges

Introduction

In India, primary health care is provided by sub-centers (SCs) and primary health centers (PHCs) in the government sector. They provide preventive, promotive, curative, and rehabilitative services to individuals, families, and communities in a systematic way. Health outcome of a health care system is dependent on motivated health care providers.

With global economy, the country has been experimenting with different models of contractualization in all sectors including health. This, however, greatly affects the quality of health care system by ignoring the motivation and satisfaction profile of human resource (HR). Contractualization is a cross-culturally established phenomenon of human resources and has resulted in the emergence of various administrative and management issues.

Scientific understanding of the efficacy of different types of HR is lacking, and the legal and administrative implications of contractual arrangement are not clearly understood by the policymakers. It is clear from several reports that conditions of various forms of employment have resulted in several issues like restricted career growth, high turnover, and low salary in comparison to regular colleagues working in the same organization for the same purpose. Increasing rate of attrition of contractual staff is a big question mark for the sustainability of contractual model in health care system. Constraints of HR in the health sector are a hindrance in achieving the health-related goals. Therefore, the present study is an attempt to explore administrative, management, and policy issues in the health care system in order to know the constraints and difficulties faced by providers in Delhi.

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Materials and Methods

The study included a sample of randomly selected medical officers (MOs; 101), auxiliary nurses and midwives (ANMs) (114), pharmacists (85), and laboratory technicians (LTs)/laboratory assistants (LAs) (33), both under regular and contractual provisions from primary urban health centers (PUHCs) in three districts of Delhi in 2013. The sample size of 333 was calculated on the basis of 10% of the cadre strength for each category of personnel. Primary data were collected using pretested semi-structured interview schedule. All the responses from providers were entered into Microsoft Excel sheet. Thereafter, each response was discussed with experts for identifying the areas of constraints and difficulties perceived by the providers. Final results of the thematic content analysis were tabulated and chi-square test was applied to find any statistical differences. Few responses which were not fitting into the themes but were crucial and important for policymakers and managers to understand are narrated as such in the results.

Results

Background profile of the health care providers is shown in detail in Tables 1a and 1b. Contractual health care providers were younger in age and had an experience of 5 years. Regular providers were in the age group of 25-45 years and having an experience of 10-15 years. Among the contractual staff, 69.8% respondents were females, whereas among the regular providers, 54.2% were females, as shown in Tables 1a and 1b.

Five major areas were identified for the different types of perceptions felt by the providers as shown in Tables 2a and 2b. The five areas were:
(i) organization physical infrastructure,
(ii) organization working environment,
(iii) privileges of staff,
(iv) discontentment, and (v) HR development.

The variables included under organization physical infrastructure were physical space, working facilities, accessibility, location, medicine, logistics, lab reagents, hand washing facility, toilets, cooling facility, heating facility, electricity, examination room, etc. Organization working environment included relationship, interaction with juniors and seniors, support from seniors, encouragement, behavioral dimension, coordination, reward system, workload, job clarity, motivation, personal sense of security, encouragement, organization policies, etc. Privileges of staff included salary, promotions, career growth, incentives, conveyance allowance, and different types of leave, e.g. study leave, medical reimbursement including cashless facility for medical treatment, provision of home loans, child education allowances, etc. Discontentment included discrimination in jobs, comparisons, dissatisfaction, undermining of authority, patient care relationship,

Table 1a: Background profile of regular and contractual health care providers in PUHCs

| Characteristic under study | MO (n = 101) | ANM (n = 114) | Pharmacist (n = 85) | LA/LT (n = 33) | Total (N = 333) |
|-----------------------------|-------------|--------------|-------------------|---------------|----------------|
| R (n = 30)                  | C (n = 71)  | R (n = 30)   | C (n = 84)        | R (n = 55)    | R (n = 118)    |
| Age <25 years               | 0 (0)       | 2 (6.7)      | 1 (1.8)           | 0 (0)         | 3 (2.5)        |
| 25-35 years                 | 7 (23.3)    | 41 (35.7)    | 10 (18.2)         | 1 (3.3)       | 49 (22.8)      |
| 35-45 years                 | 15 (50)     | 28 (39.4)    | 19 (34.5)         | 1 (3.3)       | 48 (22.3)      |
| >45 years                   | 8 (26.7)    | 1 (1.4)      | 25 (45.5)         | 0 (0)         | 44 (37.3)      |
| Total                       | 30 (71)     | 71 (30)      | 55 (30)           | 3 (10)        | 118 (215)      |
| Sex                         |             |              |                   |               |                |
| Male                        | 11 (36.7)   | 29 (40.8)    | 43 (78.2)         | 0 (0)         | 54 (45.8)      |
| Female                      | 19 (63.3)   | 42 (59.2)    | 12 (21.8)         | 3 (100)       | 64 (54.2)      |
| Total                       | 30 (71)     | 71 (30)      | 55 (30)           | 3 (10)        | 118 (215)      |

PUHCs: Primary urban health centers; R: Regular health care provider; C: Contractual health care provider; MO: Medical officer; ANM: Auxiliary Nurse and Midwife; LA/LT: Laboratory assistant/laboratory technician

Table 1b: Background profile of regular and contractual health care providers in PUHCs

| Characteristic under study | MO (n = 101) | ANM (n = 114) | Pharmacist (n = 85) | LA/LT (n = 33) | Total (N = 333) |
|-----------------------------|-------------|--------------|-------------------|---------------|----------------|
| R (n = 30)                  | C (n = 71)  | R (n = 30)   | C (n = 84)        | R (n = 55)    | R (n = 118)    |
| Qualification               |             |              |                   |               |                |
| Undergraduate Graduate      | NA          | 27 (90)      | 15 (27.3)         | 0 (0)         | 42 (35.6)      |
| Post-graduate Graduate      | 21 (70)     | 61 (85.9)    | 3 (10)            | 3 (100)       | 61 (51.7)      |
| Total                       | 30 (71)     | 88 (77)      | 18 (27.3)         | 3 (10)        | 119 (35.1)     |
| Duration of service         |             |              |                   |               |                |
| Less than 5 years           | 2 (6.7)     | 63 (88.8)    | 4 (13.3)          | 0 (0)         | 96 (29.2)      |
| 5-10 years                  | 7 (23.3)    | 5 (17.3)     | 2 (3.6)           | 2 (66.7)      | 32 (9.7)       |
| >10 years                   | 13 (43.3)   | 3 (4.2)      | 1 (3.3)           | 0 (0)         | 32 (9.7)       |
| Total                       | 30 (71)     | 71 (30)      | 55 (30)           | 3 (10)        | 118 (215)      |
Table 2a: Summary of constraints and difficulties of regular and contractual health care providers in PUHCs

| Themes of constraints and difficulties | MO (n = 101) | P value (Chi-square test) | ANM (n = 114) | P value (Chi-square test) |
|---------------------------------------|-------------|--------------------------|---------------|--------------------------|
|                                       | Regular (n = 30) | Contractual (n = 71) |  | Regular (n = 30) | Contractual (n = 84) |  |
| **Environment**                       |             |                         | 0.05**        |             |                         | 0.01**          |
| Human Resource Development             | 12 (11.8)  | 18 (17.8)               | >0.05         | 4 (3.5)  | 13 (11.4)              | >0.05          |
| Organization Working Climate           | 11 (10.8)  | 22 (21.7)               | >0.05         | 5 (3.5)  | 17 (14.9)              | >0.05          |
| Privileges                             | 1 (0.9)  | 42 (41.5)               | –             | 12 (10.5) | 27 (23.6)              | <0.01**        |
| Discontentment                         | 24 (23.7)  | 41 (40.5)               | <0.05*        | 14 (12.2) | 28 (24.5)              | >0.05          |
| Organization Infrastructure            | 22 (21.7)  | 31 (30.6)               | <0.01**       | 5 (4.3)  | 22 (19.2)              | >0.05          |
| Privileges                             | 1 (0.9)  | 42 (41.5)               | –             | 12 (10.5) | 27 (23.6)              | <0.01**        |
| Discontentment                         | 11 (10.8)  | 22 (21.7)               | >0.05         | 4 (3.5)  | 17 (14.9)              | >0.05          |
| Human Resource Development             | 12 (11.8)  | 18 (17.8)               | >0.05         | 4 (3.5)  | 13 (11.4)              | >0.05          |

*Significant at 0.05 level; **Significant at 0.01 level; PUHC: Primary urban health centers; MO: Medical Officer; ANM: Auxiliary Nurse and Midwife

Table 2b: Summary of constraints and difficulties of regular and contractual health care providers in PUHCs

| Themes of constraints and difficulties | Pharmacist (n = 85) | P value (Chi-square test) | LA/LT (n = 33) | P value (Chi-square test) |
|---------------------------------------|---------------------|--------------------------|----------------|--------------------------|
|                                       | Regular (n = 55)    | Contractual (n = 30)     | 0.05           | Regular (n = 3)            | Contractual (n = 30) | 0.05 |
| Organization's Physical Infrastructure | 26 (30.5)           | 15 (17.6)                | >0.05          | 8 (24.2)                  | 20 (60.6)            |
| Organization Working Climate          | 18 (21.1)           | 7 (8.2)                  | >0.05          | 1 (3.0)                   | 8 (24.2)             |
| Privileges                            | 10 (11.7)           | 23 (27.0)                | <0.01**        | 5 (15.1)                  | 16 (48.4)            |
| Discontentment                        | 5 (5.8)             | 9 (10.5)                 | <0.01**        | 0 (0)                     | 8 (24.2)             |
| Human Resource Development Environment | 13 (15.2)           | 7 (8.2)                  | >0.05          | 1 (3.0)                   | 2 (6.06)             |

**Significant at 0.01 level; LA/LT: Laboratory assistant/Laboratory technician; PUHC: Primary urban health centers

reporting, efficiency in administrative work in the office, personal bill reimbursement, etc. HR development included shortage of manpower, trainings, transfers in the organization, etc.

Comparative analysis showed that 23.7% of the regular MOs faced constraints and difficulties in organization physical infrastructure and 21.7% of them in organization working climate, whereas 40.5% of contractual MOs revealed constraints and difficulties in organizational physical infrastructure and 30.6% of them in organizational working climate, and these differences were statistically significant (P < 0.05). Contractual MOs revealed main difficulties for privileges attached with the job (41.5%) in comparison to regular MOs (0.9%) as shown in Table 2a.

Regular ANMs faced constraints in physical facilities (12.2%) and privileges (10.5%) in comparison to contractual ANMs who also faced main difficulties in organization physical infrastructure (24.5%) and privileges (23.6%). Difference between privileges was significant (P < 0.01). Regular pharmacists and contractual pharmacists also showed significant differences in privileges and discontentment in their job (P < 0.01) as shown in Table 2b.

Las and LTs faced difficulties in physical infrastructure, privileges, and HR development issues. Element of discontentment was also high in contractual health care providers, which included discrimination in job, comparisons, dissatisfaction, undermining of authority, patient care relationship, too much reporting from dispensaries/PUHCs, lack of efficiency in administrative work in the office of Chief District Medical Officers (CDMOs), and delay in personal bill reimbursement. Differences in privileges associated with job mainly included salary and allowances, promotions, career growth medical reimbursement, leave provisions, etc. [Table 2b].

However, some of the constraints and difficulties mentioned by providers did not fit into content or thematic analysis. Therefore, they are narrated as such, as they are important for policymakers to understand. Viewers of providers are as follows:

Regular MOs: “System is more pro-patient rather pro-doctors and seniors don’t lend helping ear/attitude.” “Attitude of patients towards doctor is not good. They are prejudiced by media that doctors are not good… Patients are not ready to wait even for 5–10 minutes. They (patients) themselves keep on talking while taking medicines. But if doctor talks on phone then they start complaining.” “Red tapeism is prevalent… top to down approach is dictatorial.” “Senior doctors should listen to junior doctor version also while dealing with patient doctor issues in dispensary. According to them, patient is always right, this theory is not always right.”

Contractual MOs: “Different rules for contractual and regular stuff, but they all are working for the same kind of job under the same roof.” “We should not feel that we are working as bonded labor, there should not be any discrimination between regular and contractual staff on the basis of rules as all the strict rules are implemented on contractual staff only with the threat of termination of job any time.” “I am working as NRHM MO and working harder than my regular colleagues while getting a pay half of theirs, always there is a threat that contract would not be extended. Is this a bad luck to become a doctor in this country and join a contractual doctor in government setup?” “Not getting salary in time for last 6 months.” “I am entitled for one leave per month only & there is no EL and medical leave. I got 4 transfers in last four months.” “In spite of being more qualified, working with sincerity, but I am looked with inferiority in the dispensary as we are contractual.”
Regular ANMs: “ANMs’ responsibilities and work are not known by other coworkers and they (ANMs) are treated like a gap filler of other staff by the MO in-charge and other staff.” “Class IV employee does not obey the orders for cleanliness and dusting.” “No promotion till our retirement; working whole life as ANM only and retiring as ANM only.”

Contractual ANMs: “Not getting the same perks as the regular ANM, but we are doing same kind of work and moreover under same roof of dispensary, and this leads to demotivation.” “Everyone in regular job thinks that all work should be done by contractual employee. All rules and regulations are for contractual staff, like punctuality discipline, sincerity, and not for regular staff.” “Lot of partiality between DHS and RCH staff. No independence in work, and boss wants to hear only what he wants to hear.”

Regular pharmacist: “Work is very boring as nothing new to do. So, not motivated now. No promotion throughout life. Pharmacist joins and retires as a pharmacist only. Allowances and salary are not motivating.”

“No growth, no promotion, no facility to study further, no cadre management. There is huge gap between higher authorities and subordinates.” “No promotion in last 30 years as I am working on same window for medicine distribution for last 30 years.”

Contractual pharmacist: “Salary is demoralizing too much, when working time and other conditions are equal to my regular colleagues and some time misbehavior by regular employees in day to day work.”

Contractual LA: “There should be equality in salary when we are doing the same work as of regular LA . . . equal work and equal pay.”

From the thematic contents, it is concluded that regular MO is relatively more biased to patients, whereas contractual MO is biased toward regular MO. Regular ANMs are not happy with the attitude of seniors toward their work. Contractual ANMs have a feeling of disparity in salary and no career growth. Regular pharmacists also have a feeling of stagnation in the organization.

Discussion

The findings are discussed under five broad types of constraints and difficulties faced while working in the organization.

Organization physical infrastructure: Health care providers perceive difficulty in discharging their duties due to inadequate facilities of physical space for working, location of dispensaries and their accessibility, logistics and medicines for dispensary, and lack of facilities for examination of patients. Providers highlighted all these constraints and difficulties. The infrastructure facilities of dispensaries got a strong bearing on the satisfaction level of health care providers. Similar finding was found in a study conducted by Sharma (1997) in ESI dispensaries where doctors were found to be dissatisfied with the working conditions of ESI dispensaries.[1]

Organization working climate: Findings reveal that the staffs are not happy with interpersonal relations (IPR) and the support and encouragement that they get from seniors. There is lack of job clarity and a feeling of insecurity in the present job. More concerns about these were shown by contractual MOs (30.6%) followed by regular MOs (21.7%), and the same was expressed by other categories of staff. The contractual staffs were relatively more concerned about their insecurity in job and this is likely to affect the motivation for work.[8] Most of the time, the contractual staff used to think how to get a better job in another organization. It became a continuous thought process of contractual employees to find ways to get better options for job in other organization, thus showing demotivation toward the present organization. In this context, the Common Review Mission (CRM) 4th report 2010 also stressed that supportive environment should be provided to contractual employees in the states for more productive output in the health sector.[9] Regarding IPR where people lack trust and confidence in each other, the climate may not be congenial for better organizational performance.[10]

Privileges: Majority of the paramedical staff were not satisfied with the job and privileges they got in the organization. CRM 4th report (2010) and CRM 6th report (2012) have also highlighted that states need to minimize the pay differences between regular and contractual staff.[9,11] A study conducted by Al Juhani et al. (2006) highlighted that professional opportunities, patient care, and financial reward are the most frequently encountered domains with which physicians were dissatisfied in the PHCs of Al-Madinah Al-Munawwara, and nursing staff were dissatisfied with professional opportunities, workload, and appreciation reward in the PHCs.[12] A study conducted in the health centers of Turkey by Bodur (2002) has shown that the job satisfaction score of midwives on items which included salary, getting along with co-workers, putting health policy into practice, receiving praise for doing a good job, freedom of self-judgment, and trying their own methods was significantly lower than that of the other health care staff.[13] Findings of the present study are supported by the results of the primary health care systems of other countries as well.

Discontentment: Feeling of discrimination and dissatisfaction in official work were the main areas of discontentment among majority of the contractual staff MOs (21.7%) and contractual LA/LTs (24.2%). Even regular MOs (10.8%) reported discontentment. Problems of disparity among regular and contractual staff are there in other states of the country also.[11,14] As reported earlier, organization policies, practices, and administration were the important areas of dissatisfaction in the organizations.[3,11]

HR development environment: HR development is an area of concern of all categories of health care providers. Such issues are also documented in CRM 5th and 6th reports in 2011 and 2012 for other states of the country.[11,14]

All types of constraints and difficulties found in the study are manageable areas. The public health care delivery system is not attractive. Professionals are less attracted and least motivated because health system is low paying, has erratic promotions, least recognition, a biased performance assessment, etc.
Constraints related to HR are a hindrance in achieving the health-related goals. Lack of attention to constraints and difficulties of providers in health is the result of the fact that governments which directly or indirectly fund the majority of health care expenditure have been primarily concerned with the macroeconomic issues, especially size of the workforce, rather than the microlevel issues of contemporary HR practices, which focus on motivation and performance of the workforce.

The quality of health services, their efficacy, efficiency, accessibility and viability depend primarily on the performance of staff who delivers them. The National Commission on Macroeconomics and Health (GOI, 2005) has identified HR as one of the key drivers of the health system.

It can be concluded that health care providers in primary health care system face enormous organizational constraints and difficulties. If the genuine constraints and difficulties of contractual staff and their insecurity, feeling of discontentment, and other genuine grievances are not addressed properly, it would result in wastage of human resources. Adopting good practices in HR management is urgently needed to ensure the sustainability of contractual model. Therefore, primary health care system needs comprehensive HR policy, keeping regular and contractual employees’ grievances at the forefront.

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