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ORIGINAL ARTICLE

Assessing the Gap in Policies of Human Resources, Quality and Communication for Indian Teaching Hospitals

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ABSTRACT

Introduction: Teaching hospital is one of the apex bodies of Indian hospital system, which is catering to much desired healthcare needs of both rural and poor urban society.

Objectives: The study examines the status of Indian teaching hospitals both government and private in the changing global scenario by assessing the gaps in their management practices based on three core parameters, i.e. human resource management, quality improvement and patient safety, and communication and patient relation through their adherence to documentation and policy with respect to the expected norms nationally and internationally. The standards were chosen from Joint Commission of International Accreditation (JCIA) in concurrence with National Accreditation Board for Hospitals and Healthcare Providers (NABH) to ensure comprehensiveness and appropriateness to Indian environment.

Design and settings: Eleven teaching hospitals were selected from the 6 divisions of Maharashtra (minimum 1 from smaller division and 2 or above from larger division). The medical superintendent was interviewed from each 11 hospital. The responses were given scores, such as 10, 5, 0 (full, partial, no compliance).

Results: The overall scores for policy/documentation were 6.29 ± 1.96, 5.00 ± 3.06 and 2.95 ± 2.48 for HRM, quality and communication respectively, among teaching hospitals. Moreover, there were significant gaps among all 6 standards of human resource management (HRM) [$F_{(5,60)} = 24.217$, $p < 0.001$], quality/safety [$F_{(5,60)} = 21.524$, $p < 0.05$] and communication [$F_{(10,55)} = 10.455$; $p < 0.05$] on their own. Indeed, these hospitals were found to be significantly behind the global standards.

Conclusion: Teaching hospitals comply with norms of staff, qualifications and department-wise infrastructure as part of Medical Council of India (MCI) regulations, which is prerequisite for global standards. So by designing hospital's policies with inclusion of some cost-effective approaches, these hospitals can attain quality services.

Keywords: Communication, Globalization, Human resource management, Teaching hospitals.

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INTRODUCTION

Teaching hospitals are the integral part of medical colleges. They are basically involved in uplifting the health status of any country. These hospitals are based on public and private healthcare models.[1,2] The public sector teaching hospitals are funded through government whereas private sector hospitals are self funded. The healthcare facilities in these hospitals are almost free.[3,4] Teaching hospitals promote research in clinical practices while extending services to the society. The advanced diagnostic and curative facilities as per the Medical Council of India (MCI) (statutory body) norms can help in producing excellence in teaching including qualified teachers, excellent biomedical research due to equipments and skilled manpower.

However, the situation is different than what is expected from the Indian teaching hospitals.[5] Government teaching hospitals are victim of overcrowding because of insufficient primary and secondary care facilities in India.[6-9] In private teaching hospitals, the administrators are struggling to match with the norms of MCI for requisite ratio of students and patients for the medical colleges.[10,11] On the other hand, the cost to maintain the resources for patient's care and research is very high due to subsidized services. The system in these hospitals is also ineffective to suggest the areas that need to be revised or expanded with the shifting demand.[12,13]

Presently, the healthcare environment is more about economic priorities for every institution due to global forces.[14,15] The shortages of skilled and qualified employees,[16] stringent government regulations, decreasing revenues are hampering the images of teaching hospitals.[4,5] The hospitals are expected to deliver effective and efficient services to become an excellent model.[17] Out of various options for acquiring qualitative care, accreditation is widely acknowledged as a comprehensive strategy.

Accreditation is the most comprehensive approach toward building quality healthcare all across the globe.[18,19]

It is suggested that the accreditation process increases focus on shaping healthcare activities patient-centric. Accreditation is one of the critical success factors for any hospitals, which also support the growth of global medicine[20] through consolidation of quality of hospital services and medical education.[21] Out of the various accreditations for hospitals across the globe, Joint Commission of International Accreditation (JCIA) is the most comprehensive framework for quality management in any organization.[22,23] It is also able to justify the international variations on quality and customize it for Indian environment by incorporating social, economical and political factors of India.[24] JCIA specifies major characteristics of excellent hospitals. They are: availability of qualified and experienced employees, quality care through safe procedures/practices and satisfaction of patients through proper communication and transparancy.[25,26]

The present study is an effort to assess the gaps in the documentations/policies of the human resource management (HRM), quality improvement and patients' safety and communication and patient relation in teaching hospitals in Maharashtra, India, with respect to international standards. The standards for above parameters were chosen from JCIA after comparing them with National Accreditation Board for Hospital and Healthcare (NABH) in order to ensure comprehensiveness and appropriateness to Indian environment.

OBJECTIVES

To assess the gap in existing policies/documentations of (a) HRM, (b) quality improvement and patient safety, and (c) communication and patient relation activities in teaching hospitals as per global norms.

MATERIALS AND METHODS

The study population was teaching hospitals (government and private) of Maharashtra—a state in India. Maharashtra constitutes almost one-tenth of the country's population including tribal and non-tribal, which varies in the healthcare accessibility, affordability and reliability.[27] It was considered as an ideal for the study due to variations in intra-state geographical, social/demographical, economical and health indicators. There are 41 teaching hospitals* (15—government, 4—municipal and 22—private) in Maharashtra.[10] Eleven teaching hospitals were selected from 6 divisions—1 from smaller and 2 or more from larger.

The questionnaire was based on structured interview format (SIF) and pre-tested during June 2011 to January 2012 to optimize it for time taken to fill each questionnaire, elimination of ambiguity and to simplify the questions to make it user-friendly. To eliminate the bias in data collection, the investigator herself conducted interviews. The standards were adopted from JCIA after comparing them with the standards of NABH (Table 1).

The responses from teaching hospitals were quantified as per JCIA evaluation criteria:[22] 10 (fully met—90% compliance), 5 (partially met—50-89% compliance) and 0 (not met—less than 49% compliance). The statistical tests were applied to see the gaps in among standards, among hospitals (public and private hospitals) as per the categories (Table 2).

The operational definition for the gap as per compliance of JCIA standards are as follows:

- One or more standards (question) had scored less than '5'.
- Aggregate score of one or more parameter of the study was less than '8'.

Table 1: Codes and standards on HRM, quality and communication

Code	*Standards of HRM*
HRM1	Recruitment and selection policies (need assessment, advertising, interview, selection and induction)
HRM2	Policies for defining/documenting job description for all employees
HRM3	Policies for maintaining personnel file for all employee
HRM4	Policies for handling grievances of employees
HRM5	Policies defined/documented for employees' education/training
HRM6	Performance appraisal/career development policies for employees
Qua1	Defined quality assurance and continuous monitoring policies
Qua2	Defined managerial policies for continual improvement
Qua3	Policies for communicating to staff and patient for safety norms
Qua4	Defined and documented preventive and breakdown maintenance
Qua5	Defined and documented hospital infection control policies
Qua6	Defined and documented biomedical waste management
Com1	Defined policies for patient and family's rights during the care plan
Com2	Defined policies for patient/family involvement in decision-making
Com3	Defined policies for grievances redressal of patients
Com4	Defined policies for patient's follow-up and feedback
Com5	Defined policies for confidentiality/security of information
Com6	Defined policies for communication of financial implications

*The sampling was done in 2012, so the number of teaching hospitals mentioned 41 as existing that time

Table 2: Unit of analysis (indicators)

Statistical test	*F-test*	*F-test*	*t-test*
Parameters	*Policy/documentation*		
HRM, quality and communication	Mean score standard-wise for 11 hospitals	Comparison among hospitals	Comparison of public and private hospitals

RESULTS AND DISCUSSION

The results show that the scores pertaining to 11 hospitals concerning their policy/documentation with regard to HRM, quality/safety and communication. The standard HRM1 and Qua6 were received 10 (more than 90% compliances).

Human Resource Management

There were significant gaps among all 6 standards of HRM [$F_{(5, 60)} = 24.217$, $p < 0.001$]. It was realised that the policies like recruitment and personnel file as a mandatory criteria for any medical college, scored good. The personnel files for teaching staff were found to be updated but files for nonteaching staff; administrative and utility staff were either not updated or not created at all in some hospitals (Table 3). The job profiles for the employees were not given at the time of recruitment nor even during transfer or promotion. The MCI criteria for teaching staff were referred as the expected job profile commonly known to employees. The verbal instructions for performing day to day work were the only job profile in these hospitals. Similarly, handling grievances of the employees could not supported by documentary evidences. However, some ad hoc committees were constituted for handling various issues pointed out during the interview as compliances. None of the hospitals responded positively for detailed policies regarding scheduling training need assessment, allocating training budgets, preparing documents or training calendars in their hospitals. The unmet needs of performance appraisal due to lack of proper policy guidelines showed that the performance reviews for employees had been grossly ignored resulting poor job satisfaction among them. The career development activities were not documented and defined. The management could furnish only little information verbally.

Quality Improvement and Patient Safety

There were significant gaps among all 6 standards of quality/safety [$F_{(5,60)} = 21.524$, $p < 0.05$] due to some mandatory and some good to have standards. The first common observation the research had during the interviews as the lack of understanding of quality frameworks and indicators among administrators. As a result Qua1 and Qua2 were almost scored either 0 or 5 in these hospitals. Similarly, the education about staff and patients on

Table 3: Human resource management, quality and communication standards of Maharashtra, India

Codes	*H1*	*H2*	*H3*	*H4*	*H5*	*H6*	*H7*	*H8*	*H9*	*H10*	*H11*	*Mean of std*
						HRM						
HRM1	10	10	10	10	10	10	10	10	10	10	10	10.00 ± 0
HRM2	5	5	5	5	5	5	5	5	5	5	5	5.00 ± 0
HRM3	5	5	5	5	5	5	10	10	10	5	10	6.82 ± 2.25
HRM4	5	5	5	5	5	5	5	5	5	5	5	5.00 ± 0
HRM5	5	5	5	5	5	5	5	5	5	5	5	5.00 ± 0
HRM6	5	5	5	5	5	5	5	10	5	5	10	5.91 ± 2.02
Average of hospitals	5.83	5.83	5.83	5.83	5.83	5.83	6.67	7.50	6.67	5.83	7.50	6.29 ± 0.69/1.96
						Quality/safety						
Qua1	0	0	0	0	0	0	5	5	5	5	5	2.27 ± 2.61
Qua2	0	0	0	0	0	0	5	5	5	0	5	1.82 ± 2.52
Qua3	5	5	5	5	5	5	5	5	5	5	5	5.00 ± 0
Qua4	5	0	5	0	5	0	5	5	5	5	10	4.09 ± 3.02
Qua5	5	5	5	5	5	5	10	10	10	5	10	6.82 ± 2.52
Qua6	10	10	10	10	10	10	10	10	10	10	10	10.00 ± 0
Average of hospitals	4.17	3.33	4.17	3.33	4.17	3.33	6.67	6.67	6.67	5.00	7.50	5.00 ± 1.58/3.06
						Communication						
Com1	0	0	0	0	0	0	5	5	5	5	5	2.27 ± 2.61
Com2	5	0	0	0	0	0	5	5	5	5	5	2.73 ± 2.61
Com3	5	0	0	0	0	0	5	5	5	5	5	2.73 ± 2.61
Com4	5	0	0	0	0	0	5	5	5	5	5	2.73 ± 2.61
Com5	5	5	5	5	5	5	5	5	5	5	5	5.00 ± 0
Com6	0	0	0	0	0	0	5	5	5	5	5	2.27 ± 2.61
Average of hospitals	3.33	0.83	0.83	0.83	0.83	0.83	5.00	5.00	5.00	5.00	5.00	2.95 ± 2.09/2.48

H1-H11: Hospitals

safety norms and preventive or breakdown maintenance were found to be ignored widely. In some cases, the equipments were found out of order. Patients were referred to private diagnostic centers because of delay in repairing or nonavailability of replacements.

Administrators did not quote supportive documentations often. Hospital infection control mechanism could not be considered with full compliance due to lack of policies for employees' training, awareness or education. Indeed, the only policies scored good was biomedical waste management. The policy/documentation for quality assurance and continuous monitoring were found inadequate in teaching hospitals. It may be because MCI does not make quality/safety as one of the mandatory criteria for certification. Few initiatives toward safety policies like fire safety were found in their beginning stages for documentation.

Communication and Patient Relation

There were significant gaps among all 6 standards of communication [$F_{(10,55)} = 10.455$; $p < 0.05$] on their own. Except maintaining confidentiality of patients' information, all other standard policies got less than 49% compliances. Patients' involvement in decision-making as a right during the care plan, follow-up and feedback and above all the communication of financial implications were not documented at all in many hospitals. There were no defined policies for grievances redressal of patients in all public teaching hospitals. However, in some private hospitals special administrators were appointed to look after day-to-day issues of patients. The periodic patients' feedback survey policies in private hospitals were also considered as a part of the compliance of the Com2 standard. All public hospitals received 0 (except H1), which is alarming. There were no defined policies in teaching hospitals that how the patients will be informed for the financial implications during the procedures or incase of any change in care plan.

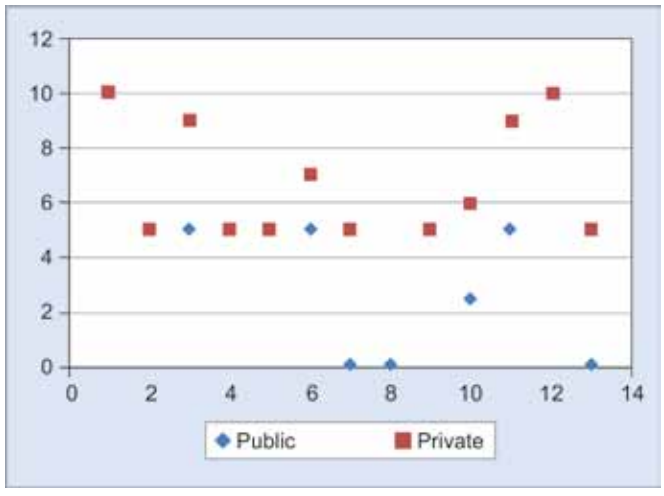
Public and Private Teaching Hospitals

Pertaining to the HRM policies, both private and public hospitals found to have similar trends in score. Private hospitals accepted multitasking and, in public hospitals, heavy workload was quoted as a reason for partial compliance against some standards. The score for quality and safety shows that private hospitals have started acknowledging these standards but not significantly different than the public hospitals. The public hospitals were found to be relatively behind the private hospitals (Table 3 and Graph 1), especially in terms of updating communication policies [$t_{(10)} = 4.88$; $p < 0.05$].

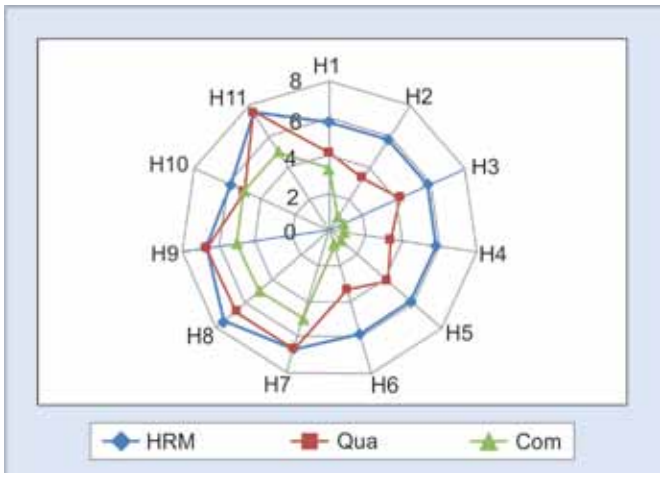
Comprehensive Analysis of the Documentation and Policies in Teaching Hospitals

The comparative analysis of the hospitals for compliance of these parameters (Graph 2) shows that there was the significant difference among the hospitals [$F_{(10,55)} = 10.455$; $p < 0.05$]. Hospitals H2, H3, H4, H5 and H6 were significantly away from H7, H8, H9, H10 and H11.

As per operational definition of gap, out of total 18 standards selected for study 8 standards (3 quality/safety, 5 communication) were scored less than 5, i.e. <49% compliance. Similarly, none of the parameter received the aggregate score 8 (Table 4). The overall score for policy/documentation were 6.29 ± 1.96, 5.00 ± 3.06 and 2.95 ± 2.48 for HRM, quality and communication respectively, among teaching hospitals (Graph 2).



Graph 1: Human resource management, quality and communication in public and private teaching hospitals of Maharashtra, India



Graph 2: Comparative analysis of the hospitals for HRM, quality and communication

Table 4: Number of standards received <49% compliances

HRM	*Quality/safety*	*Communication*	*Total stds*	*% of stds <5*
0/6	3/6	5 /6	8/18	44.44%

CONCLUSION

The gap analysis reveals that the teaching hospitals have to work harder to match with international standards as they are much behind the international norms. However, MCI enforces provision for staff, qualifications and department-wise infrastructure, which are the pre-requisite for global standards. Indeed, these hospitals can look forward for acquiring the excellence if, they design hospital's policies with inclusion of some basic standards, which can help these hospitals to attain the cost-effective approach toward image building and quality services.

Hospital's policies need to address nonteaching staff also which are mostly ignored. Similarly, standards which are not mandatory by MCI, like job description for all employees, grievances redressal, and performance appraisal, should be included in the system effectively for having better administrative efficiencies. Efforts should be made for considering employees' grievances as these are important parameters for employees' satisfaction and better participation in the hospital.

There has to be policies on managerial responsibilities, indicators for assessment and parameters for continuous improvement in the hospital. It can be followed by training activities, objectives, budget allocation, session planning or scheduling of educational activities for all employees. The hospitals should update the equipments with adequate preventive and breakdown maintenance plan and policies.

The infection control initiatives, formation of multi-disciplinary committee, periodic infection control test, evaluation, outcome, meetings and plan of action, etc. in form of policies/documentations should be given much importance.

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CONTRIBUTORSHIP STATEMENT

I, on behalf of my coauthor, declare that both of us have conceptualized the study thoroughly. We have analyzed and interpreted the data. We have drafted the work and revised it critically for important intellectual content. My coauthor being the guide has given final approval of the version to be published, and we agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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