Measuring Entrepreneurial Orientation towards Health Care Sector in Kerala, India
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ABSTRACT
This paper focuses on the skills, characteristics and personality traits of owner’s managers. Many countries are working on the realization of a new sort of public management, which is less governmental and more market oriented. As a consequence the role of health-care managers is changing. They are increasingly addressed as (social) entrepreneurs. This article is based on the results of a survey sent to health-care executives in Kerala, India. The aim of the survey was to explore how the new discourse affects the practice of management. The results show that entrepreneurship is a construction and a contested concept. Nevertheless, executives are very sensitive to the concept. It certainly confuses them and can make them feel more vulnerable. However, new expectations can also perform an important function as a catalyst for executives to rethink their role and their position. From that point of view the phase of multiinterpretable expectations and vague discourse can be seen as a necessary phase in realizing health-care reform.

Introduction
This study is about what entrepreneurship in health care means. The central argument is based on two perspectives: that of policymakers and their policy plans and that of health-care executives (end-responsible managers of health-care organizations). The aim is to provide more insight into the relationship between new policy ideals on the one hand and managerial practice on the other. The central question is: How do Kerala health-care executives cope with the new ideal of entrepreneurship? The broader question, of course, is about the function of expectations and discourse (language use) in policy reform. Entrepreneurship is often described as the ability to create ventures from new or existing concepts, ideas and visions. There has been significant entrepreneurial response to the changes in the scientific and social underpinnings of health care services delivery. A hospital is a crucial organization that stands unique and incomparable to any other business enterprise. It is unique and special because it deals with life of mankind. Patients are not just attracted by high-tech hospitals rather the demand for devoted doctors, accurate diagnostic facilities, qualified nurses and supporting services are important. Establishment of a hospital requires careful planning.

Kerala has to its credit a fairly developed healthcare infrastructure and Kerala has a long history of organized health care. When the State was founded in 1956, the foundation for a sound health care system had already been laid. Thereafter, there was remarkable growth and expansion of government health services. The number of beds in government hospitals rose from 13,000 in 1960 to 38,000 in 1996. The annual compound rate of government expenditure on health during that period was higher than the compound rate of total government expenditure and higher than the annual compound rate of growth of the state domestic product. The easy accessibility and coverage of medical care facilities has played a dominant role in shaping the health status of Kerala. Some of the hospitals in Kerala are more than 50 years old. Health had been a major area of spending in the budget from early years in Kerala (Gangadharan, 2005).

The growth of health facilities in Kerala offers many lessons in development. The active role of the state government has seen a key factor in the expansion of health care facilities. The initial period of rapid growth in health facilities was dominated by the public sector up to the 1980s. By the mid 1980s because of fiscal and other problems, there was a slow down in the growth of government health institutions. This affected not only the growth in absolute number of beds, but probably the maintenance of quality as well. However, by this time, the private sector was paired for growth and it took the lead in the growth of health care facilities in Kerala. The growth of the private sector in Kerala should not be seen as independent phenomena. The public sector paved the way for its development by sensitizing the population to the need for sophisticated care and creating demand. The government continues to play leadership role in the training of all strata of health professionals, who are then largely absorbed by the private sector. Factors outside the health field, such a growing income, improvement of literacy and population ageing all contributed to this trend. Kerala knows for its model of ‘Good Health at Low cost’ achieved through universal availability, accessibility and performance of government healthcare delivery system to even poorer sections of the society. Competition from govt. facilities often serves as an impo

Literature Review
Chrimule & Amaradha (1998) try to identify the factors influencing decisions regarding the type of health services to be used, and to study the preferences to the people regarding the choice of health care provider in relation to their socio economic background to identify necessary interventions for increasing the reach of health services to the poor people. The study concluded that the utilization pattern of health services is determined by many factors such as cost, quality of services, their availability, etc. However quality of services plays a dominant role in
people’s decision about seeking medical help. The study shows that due to the inefficiency of the Public Health Centers people prefer seeking treatment from private practitioners.

Banerji (1994) conducted a study in the development of health services in India. The main theme of this paper is to place issues concerning health services in India with in the South Asian context. There continue to be numerous serious problems in the field of health and health services in this region. Over the years, particularly in the recent past, there has been a tendency among some responsible international organizations and aid agencies to paint the conditions prevailing in this region in colors which are darker than those warranted by available evidence. Their database is often dubious, their analysis superficial and highly skewed and above all, they are patently a historical in arriving at their conclusions. However, an enormous amount of work has been undertaken by scholars in this region in studying health and health services in a broader context.

Comparative studies of health facility cost and efficiency have to overcome the difficult methodological problems arising from the wide diversity of health care activities produced by alternative providers and the effects that such heterogeneity has on resource use, cost, and efficiency. The case mix approach attempts to standardize hospital output according to the mix of cases actually treated in the hospital. The case mix denotes composition as well as complexity of cases while measuring hospital cost, these two aspects are of utmost importance and need to be considered. Bruning & Register (1987) in their comparative study of efficiency between profit and non-profit oriented U S hospitals have used an alternative method for dealing with case mix, since the information on case mix of individual hospitals was not available .Case mix proxies are used to limit the confounding effects of case heterogeneity on efficiency measures. They assumed that rural and urban hospitals differ in their case mix and therefore confined to only urban hospitals in their study. All long-term (older) federal hospitals are also eliminated from the sample to reduce heterogeneity. Hospitals that provide a specified set of services are retained, thus eliminating all hospitals, which are too ‘basic’ or ‘high tech’. It is noted that hospital size, measured by the number of beds, is also associated with the case mix .Therefore, they limited their sample to hospitals within the range of 100 to 200 beds. To verify their hypothesis that hospital size is associated with case-mix, the authors group the sample hospitals by size and compare the groups on the basis of bed-to-doctor and bed-to-nurse ratios .The differences in ratios are interpreted as differences in case mix .However, it should be noted that the above procedure might introduce a bias in their analysis because bed-to-labor ratios may reflect not only case mix but also efficiency differences. The authors have also estimated technical efficiency using multiple-output production function approach. This estimation method allowed them to control case mix composition, while the previous procedure of restricting the sample could control the case complexity as well

Bridgeman (1974) discussed the role of hospitals in the past, presents and predicted into the future. He developed different model systems for a hospital with particular reference to developing countries where financial and manpower resources are restricted. He suggests that hospitals have to widen the scope of their activities in becoming an essential tool in delivering total healthcare to the community.

Nabae (1997) in his article has analyzed the past accomplishment and new challenges faced by the health care system in Kerala. He also suggests some measures to overcome the challenges faced by the public sector over the private sector. He suggests that, Kerala must invest in the public sector to revitalize the system. To achieve this, tax revenue must be increased. Second, Kerala must streamline the system through decentralization. Third, Kerala must take a step to revamp the health care system in a way that the public and private sectors effectively co-operate and complement each other to meet the needs of the people.

Panikan(2004) in his special article had examined the achievements of Kerala in the health field .His primary focus is on the rural population who generally constitute the predominant majority. The conclusion to which this case study leads is that given proper policies and priorities, lack of resources need not be an impediment to improve health status even in low income countries.

Gangadhavan(2007) have examined the success indicators of health in Kerala with that of the national health and the issues connected with the health care investments and morbidity prevalence in Kerala. The study has great relevance in the present socio economic and environmental contest. The state Kerala which has been considered as a state with advanced human development index and better health status is now ailing from acute morbidities of different communicable and chronic illness. Since high morbidity prevalence in the basic issue of the Kerala’s health sector, greater attention is needed to reduce the intense morbidity prevalence private health care can only be a complementary to public institution and not as a substitute to achieve health for all at least in the near future. To attain the status of health for all, aged population has to be properly rehabilitated and efforts should be made to augment the utilization of health services among the marginal deprived and venerable sections of the society. Moreover there should be better of safe drinking water sanitation and utmost care should be provided for better environmental cleaners both in the urban and rural areas.

Significance of the Study
Kerala has a long history of organized health care. When the State was founded in 1956, the foundation for a sound health care system had already been laid. Kerala has a vast health care infrastructure under Allopathy. Ayurveda and Homoeopathy system of medicine. In the health sector the role of Allopathy stream is very important and the major participation is focused in the Allopathic sector which has hospitals both in the private and public sector .Therefore the paper proposed to conduct a detailed study of the entrepreneurial orientation towards Health care sector in Kerala, India

Objectives of the Study
• To provide insight in to the meaning of entrepreneurship in health care ,especially from the point of view of health care executives

Hypotheses of the Study
The Hypotheses of the entire study was designed as follows.
• Entrepreneurs who perceive themselves as entrepreneurs are more likely to behave in an entrepreneurial way.
• Entrepreneurship (role perception and managerial practice) is likely to be shaped by managerial background.
• Entrepreneurship (role perception and managerial practice) is likely to be shaped by sector characteristics

Research Methodology
The research is designed as both explorative and descriptive. So the major data source is primary in character. The secondary data were elicited from books, reports, monographs and the official record of the government. The three types of executives were tested for differences in managerial
practice, managerial background and sector. To find associations, chi-square was used.

Population for the Study
Entrepreneurs in the private hospitals operating in Kerala over the 14 districts stretching from Thiruvanthapuram to Kasargod constituted the population and the samples are drawn from them.

Sampling Design
The sample units for the study is selected by multi stage stratified random sampling. First of all the total population is divided into two strata based on region and based on bed strength of each selected hospitals. Based on regions sample units are selected from the Northern, Southern and Central part of Kerala. Ernakulam district representing central Kerala and Thiruvanthapuram district from the southern region constitutes the sample district. Then the total number of hospitals in private sector is being listed by assigning serial numbers. The bed strength ranging below 50, between 51-150, and above 150 forms the group. After stratifying the population on bed strength, the sample entrepreneurs are drawn randomly by lot method for the purpose of the study. From each division samples are selected in such a way as to ensure that at least 10 percentages of the units are chosen as the sample.

Results and Discussions
In order to unravel how the ideal of entrepreneurship affects health-care executives and their work, the interaction between executives’ role perceptions and managerial practice needs to be investigated, as well as the role played by managerial background and sector. In conceptual terms, this means exploring the correlations among the variables’ role perceptions, managerial practice, sector and managerial background, which appear to be crucial for understanding how health-care executives cope with new role expectations.

Entrepreneurially minded executives are more likely to behave in an entrepreneurial way
Do entrepreneurs, liaisons and strategists behave differently and does this behavior seem consistent with their role perceptions? In order to find out what executives meant by ‘entrepreneurship’, no expectations were formulated about managerial behaviour.

Most executives seem to behave in line with their frame of reference. There is evidence that entrepreneurs behave differently from strategists and liaisons, although differences between entrepreneurs and strategists are sometimes subtle. Entrepreneurs are the most active leaders of professionals: they show little patience and little sympathy with professionals and have the least trust in professional self management. Entrepreneurs realize most changes in organizational structures and in the strategic apex. They have the most outward orientation and are likely to take part in more national committees but spend the least time with subordinate managers. Liaisons spend much time in the organization and on organizational matters of an operational nature. They show more consideration in regard to professional practices and are more careful about unsettling management interventions, such as changes in organizational structure. The strategists are the most puzzling. In their actions they look a lot like Entrepreneurs but are less extreme. The main difference between entrepreneurs and strategists is their relationship with subordinate managers. Strategists spend significantly more time with subordinate managers than entrepreneurs do. The impression arising from the research is that strategists take more time to make changes than entrepreneurs do and they might steer in an indirect way.

The most striking finding is that there was no single difference in competitive behavior. Entrepreneurs did not act more aggressively, nor were they more likely to interpret production information as an indication for their competitive position.

The results support the hypothesis that executives who perceive themselves as entrepreneurs are more likely to behave in an entrepreneurial way. The results suggest that in practice, entrepreneurship mainly means ‘an active style of managing professionals’, ‘changing organizational structures’ and ‘focusing on issues of an external and strategic nature’.

Entrepreneurship is likely to be shaped by managerial background
Entrepreneurs followed significantly more management courses than the others did and started significantly earlier in their career in a management position. Moreover, it appears that entrepreneurs have the most diverse experience as managers: they had the most job changes and had the most experience in end-responsible positions and in different kinds of organizations, including some outside of health care (although these last differences were not significant). Closer look at the outcomes (including the non-significant ones) gives the impression that liaisons are likely to be trained on the job. In health care, this is mostly in the same sector, in one and the same organization and with fewer management positions. Strategists do not stand out in any specific way; on most issues they hold the middle ground between liaisons and entrepreneurs.

The results show that ‘to have attended several managerial courses’ and ‘to have acquired experience in a range of management positions’ are indicators for an entrepreneurial mind. This means that there is evidence that role perception is shaped by managerial background. The study shows that the more ‘(recently) educated’ and the more ‘(diversely) experienced’ executives are also the more ‘active’ executives: the more plans they have for change, the busier they are with the competitive position of the organization, the more active they are in external, national committees and other organizations, the more they participate on supervisory boards. The most experienced executives concentrate more on strategic issues.

Relationship between managerial practice and managerial background
Taking into account the outcomes shown in Tables 3 and 4, it becomes clear that entrepreneurs are likely to be those who have the most managerial training and the most experience as managers and that this is related to a very active management style. The outcomes support the hypothesis that entrepreneurship is likely to be shaped by managerial background.

Entrepreneurship is likely to be shaped by sector
No single relationship was found between role perception and sector. Executives from different types of organizations held the same ideas about their role, which is remarkable because they do not act the same. Sector is correlated with managerial practice in many ways, with the sector being typified by the way executives of a specific type of organization stand out (are more or less likely to think or do something) in relation to executives of other types of organizations.

The outcomes support the ‘sector logic’ that organizational customs and traditions differ by sector. Executives of health-care organizations are situational leaders. In different sectors, with different professionals, executives approach professionals differently. In different sectors, with different stakeholders, the urge to merge and to introduce new services differs, and executives focus on different external parties. It is interesting that executives do not seem to be conscious of this; no relationship was found between role perception and sector.
characteristics. It is possible that this is because role perception and sector are related to different aspects of managerial practice. Rather than supporting executives’ actions, it could be possible that sector characteristics elicit actions that interfere with executives’ intentions. In conclusion, despite the proof of a ‘sector logic’, hypothesis three (‘entrepreneurship is likely to be shaped by sector characteristics’) must be dismissed. Although sector characteristics do influence managerial practice, they do not support entrepreneurs in their intended actions.

The study reveals that

- Executives prove to be very sensitive about the opinions and ideals pressed upon them by policymakers and the media. Although the ideal of entrepreneurship is still vague, executives widely believe that the appropriate perception of their role is to see oneself as an entrepreneur.
- Entrepreneurship is more than discourse alone. The ideal of entrepreneurship is evident in their actions. Entrepreneurially minded executives are more active and involved managers, not only in managing professionals, but also in meeting the outside world, and they have more of an eye for strategic issues. They engage in more changes (especially regarding organizational structures) than other executives do.
- Confirm executives in their ‘culturally shaped and socially constructed beliefs about their role. More and broader work experience appears to enhance an executive’s “antenna” for the appropriate behaviour. The combination of more work experience and managerial training supports executives in an active management style, an external orientation and more attention to strategic issues. Experienced and well-trained executives (like the entrepreneurs in this study) are more ‘on the ball’ in a rapidly changing environment than strategists and liaisons are.
- Executives are situational leaders. Sector characteristics influence managerial practices in many ways, but this ‘sector logic’ can prove hard to resist and might interfere with executive’s intentions. As a consequence, executives in different types of organizations are likely to cope with entrepreneurship differently.

Conclusion and Limitations of the Study

It can be concluded from this study that entrepreneurship in health care is a construction and a contested concept. The entrepreneurial discourse is vague. It combines persuasive optimism with realism about changes that may be feasible in the near future. At first glance, it appears to result in confused executives. Interpretations of the concept differ even among the executives themselves. However, this study also shows that discourse can have an important function as a catalyst by making executives rethink their role, their function, their personal qualifications, which position to take and which actions to make. Last, it is important to realize that in the new system the position of health-care executives is no longer legitimized by policy plans formulated by government bodies. Instead, legitimization must come from clients and other stakeholders like insurers, banks, etc. These other parties in health care may have different interests, and they are likely to operate in another ‘logic’ with different rules and habits. The major limitation for this study is that it has not covered the other types of institutions in the health sector such as Ayurvedic, Homeopathic, and Unani etc and it has become difficult for the researcher to collect data from different hospitals. Perceptions of the respondents are measured through observation, personal interview, questionnaire and schedules. The power structure in India may cause respondents to answer with partially frank acknowledgement of feelings. It became very difficult to meet and elicit opinion of administrators due to their busy schedules. Majority of administrators are under the impression that research on management means probing in to their internal affairs especially in health care sector. With this opinion they hesitated in providing required data. Another limitation is that the above analyzed data is not sufficient to study about the entrepreneurship in healthcare in Kerala.

References


