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Public Hospital Reforms in India, China and South East Asia: Consequences for Accountability and Governance

Title of the paper

'On-Contract' Healthcare Personnel in Government Services – Issues and Implications for patient care in India

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Abstract

The introduction of market reforms since 1990s has seen experimentation with many strategies to reduce the government's health bill. One such measure aiming at better human resource management is the recruitment of health workers on temporary contracting terms. In an institutional setting this has created a demoralized workforce characterized with insecure jobs, dismal pays, fewer leaves, and no possibility of professional growth. This paper examines the implication of contract work for health care delivery, through insights from a qualitative study conducted in a tertiary government hospital in Delhi. Evidence from the study indicates that coexistence of permanent and contract staff side by side has dynamics which weaken the organizational culture, and restricts the quality of healthcare being rendered to patients.

Key words

Contracting, health workers, hospital reforms, morale and aspirations, organizational culture, outsourcing

I. Introduction - Health reforms in India – overview

Health sector reforms were initiated in the 1990s, as part of the Structural Adjustment Programme imposed by the World Bank and International Monetary Fund, through conditional loans to developing nations for overcoming the financial crisis in the 1980s. These reforms were based on the tenets of improving efficiency, effectiveness and quality of care in public health services. "*The key ingredient in the reform process include the cutting back off public*

expenditure, selective *state intervention, and a greater role for markets in providing curative services"* (Baru, 2002). The reforms placed a strong emphasis on restructuring public health services by contracting out of ancillary services, scaling down manpower and decentralization. In addition reforms often presume a more dominant role for the private market in finance, provision, technology and research of health care. *Some of these measures/mechanisms included 'the demarcation of public goods and private goods; preventive services as the responsibility of the State and curative services of the market; the separation of the primary level from secondary and tertiary; introduction of user fees; decentralization; public-private mix, etc. These elements resulted in redefinition of the role of the State, from a central one in financing and provisioning to a fragmented one as part provider and regulator*. (Baru & Bisht, 2010)

The World Development Report 1993 – investing in health, was an important document that guided the reform process in India and other nations. It identified inefficient use of funds and rising health care costs as the problem inflicting public systems. The bank advocated reallocating government resources from tertiary facilities to primary care, and calling private players to fulfill the unmet needs at tertiary level. The solution was sought by promoting private and social insurance and competition in health services delivery. The report reads - "*There is also considerable scope for improving the quality and efficiency of government health services through a combination of decentralization, performance based incentives for managers and clinicians, and related training and development of management systems. Exposing the public sector to competition with private suppliers can help to spur such improvements*". (World-Bank-WDR, 1993)

The rationale for introducing Health reforms was the economic logic, whereby cost inefficiencies of the public sector had to be corrected. Twaddle associates these reforms as focusing "*more on*

efficiency than on effectiveness or equity". (Twaddle, 1996). The reforms were based on concept of New Public Management' - a solution conceived by developed world using business principles for improving the public sector inefficient systems, of which health was one part. This was a market driven model, where quality, costs and efficiency ensured by competition between providers and informed consumers was the formula to ensure the optimal provisioning.

In India, the uptake of reforms has not been a very uniform process. Different Indian states have undertaken different reforms suited to their needs, and often due to external assistance from donors. Some of the main reforms undertaken include - imposition of user fees in public facilities; reforms in drugs procurement; contracting of ancillary services like sanitation laundry, ambulatory services, cafeteria, etc.; Contracting appointments of medical and para medical personnel; Public–private partnership (PPP) for running government owned units like PHCs, Dialysis centres, etc; and social insurance schemes in partnership with private units.

The use of contracting labour and other health services has been premised on the logic of their cost efficiency. *Discourses on 'new public management' since the late 1980s for making public organizations more accountable, flexible and 'business like' (Condery and Ledwinka, 2008) have driven public sector institutions including healthcare to adopt such a paradigmatic shift. This has encouraged contractualisation of employment of several categories of health personnel*. (Thressia, 2016) The hiring of staff on contractual basis allows the freedom for hire and fire, no liability for pension benefits, nor the responsibility of social security cover. Often the salary slabs of contract staff finds parallel with salary structures in the private sector. Even the number of leaves is fewer for contracted staff.

However evidence from studies across India, and literature emanating from labour union writings indicate a very low morale among contract employees (Thressia, 2016), (Kumar & Khan, 2013), (Basu, 2016); that is ultimately leading to compromises on quality of health services. The position of human resource in the health care system is unique, in the sense that unlike any other sector, the human touch is essential for patient's care. Therefore, the health care provider's demands for personal development and job satisfaction have to be recognized as quality indicators. (Kumar P. , Khan, Inder, & Mehra, 2014)This paper examines the characteristics of contract work within a public sector hospital, its dynamics and implications for patient care, from a study conducted in a tertiary hospital in Delhi.

II. The study and its methodology

This paper is a result of an ongoing study that explores the consequences of commercialization for public health institutions. The concept of commercialization allows the researcher to examine the relationships between markets and state owned health facilities, and accounts for the accommodation to market principles for bringing efficiency in public health facilities. According to Mackintosh, "*by commercialized health care we mean: the provision of health care services through market relationships to those able to pay; investment in, and production of, those services, and of inputs to them, for cash income or profit, including private contracting and supply to publicly financed health care; and health care finance derived from individual payment and private insurance […] This concept of commercialization is thus wider than the 'private sector' of provision and finance, encompassing, for example, commercial behavior by publicly owned bodies. It is also broader than 'liberalization' and 'marketization', each of which refers to a shift to market-led provision from state-led or state-constrained systems, and broader than*

'privatization', which refers to the sale or transfer of state-owned assets into private hands.(Mackintosh & Koivusalo, 2005)

Health sector reforms, which were premised on the logic of markets, are a marker for the entry of commercial interests in health. The promotion of private players for services provision, and the adherence to business principles for better management of hospital functions have introduced significant changes in the structure of public health services. The larger study examines the consequences of health sector reforms for the functioning of a public sector hospital. The study has been designed as an institutional ethnography of a tertiary level public hospital in Delhi, where perceptions of hospital staff provide a window for understanding what health reforms have entailed for the functioning of a public hospital. The study aims at documenting what specific reforms were made within a public sector hospital, how these reforms were perceived by the hospital staff, and what consequences have these reforms made in the hospital functioning.

The inspiration for such a study comes from a limited understanding of hospital reforms or institutional reforms. Even after two decades of health reforms, not much insight is available on what these reforms have reaped for health systems functioning in India. A lot of academic work on Health reforms in India has focused on the general understanding of reforms; the critical issues that health reform poses; the ideology behind the reforms; the growth of a vibrant private sector; the ethical consideration of promoting the private sector over the public sector, and understanding state wise reform initiatives. However, there are no micro level studies looking within a particular health institution; say a government hospital, or a dispensary, to see what the experience of reforms has been. It is this gap which the present study will try to document.

The present paper builds upon one such reforms initiative – the recruitment of hospital staff on contract basis – in place of permanent employees. This has been one of the most striking features of reform process, which was aimed reducing the burden of salaries in the health budget through reforms in human resources management. According to a 2001 study by Selvaraju, 60 percent of health budget accounted only for the share of salaries. (V.Selvaraju & Annigeri, 2001, p. 5) Human resources in public services with permanent jobs have fair salary scales, including a good provision of leaves, and many allowances in addition to long term pension benefits. Thus, once inducted, the permanent employees become a huge financial liability of the government.

The initial response of the government has been downsizing, whereby the process of induction has been slowed down, and further intake of public servants is being curtailed. The restriction on filling up the posts after superannuation has been followed as per the new economic policy. As more and more people are retiring, organizations are suffering with manpower crunch. The deficiency in the functioning of health organizations has become a major challenge. (Kumar & Khan, 2013)

While the exact situation for health sector is not known, however Kuldeep Mathur writes about the general trend in Indian bureaucracy. "*The effort at reducing the size of the government began with successive budgets presented by the union finance minister from 1992. […]In a bid to bring down fiscal prudence and austerity, the centre imposed a 10 percent cut across the board in the number of sanctioned posts as on 1st January 1992. The Fifth pay commission report contained a recommendation for a whopping one third cut in government size in ten years. The downsizing exercise was later taken up by the Expenditure Commission, which further recommended a cut in the number of sanctioned posts as on 1st January 2000*." (Mathur, 2008)

This gradually increases the work burden on existing staff. Within health sector, this led to severe shortage of manpower for all sections of workers, since the patient burden on hospitals has over the years further increased. While the private sector has grown considerably since the 1990s, however this has in no way alleviated burden of patients in public hospitals. The shortage of required personnel in such scenario creates operational barriers, delay in delivery of services, a long waiting time, and an overworked and stressed workforce.

Since 2000, the Delhi government has introduced recruitments through contract and outsourcing staff through a third party, instead of permanent selections. Within these arrangements the employees are recruited by the Hospital Administration under a contract for a fixed term (of 11 months), at a fixed monthly salary. The outsourced staff is recruited by a third party – agency or person, which is selected through a tendering process for a fixed budget, and salary is paid to the employees by the contractor. In both these forms, the responsibility of the government as an employer becomes minimal. They have no liability to provide any social security or job security cover, or health benefits, or pension. Even the quanta of leaves for contract staff are significantly lower than permanent staff. In a related study on constraints pertaining to contract inductions the authors noted that "*Contractual recruitment modality is easy with a low financial burden on the government. The policy-makers at the national level think that contractual staff is more amenable to work pressure than the regular work-force. The contractual staff could be easily replaced in case they fail to achieve the desired targets*." (Kumar & Khan, 2013)

The present paper delineates the characteristics of contract work in a public health setting and its implication on services delivery. The study uses qualitative methods to understand the perceptions of employees, and their experience with human services reforms. The study was conducted within a tertiary public hospital under Delhi government administration. Prior written

consent from State Health department was solicited for conducting the study. Additionally consent from Hospital Head, and individual consent from all participants was taken before conducting the interviews. Unstructured in-depth interviews will all categories of hospital staff – doctors, nursing staff, technical staff, nursing orderlies, and cleaning staff, as per their terms of contract, i.e. permanent, contracted, private outsourced, was done. Observation of day to day hospital activities also supplemented the data collected through interviews.

The interviews were conducted over a period of eight months, from September 2016 till May 2017. A total of 72 staff members were interviewed, of which 11 were on contract, and 10 were outsourced. The inclusion of less numbers of contract and outsourced staff has been on account of the hospital administration's greater identification with permanent staff as suited employees. However on repeated insistence, the researcher was given permission to interview contracted and outsourced staff. The researcher visited the hospital on all working days, during general shift timings, i.e. 9 am to 4 pm. The researcher was able to establish a good rapport with the participants, which yielded in rich and informative interviews.

The following section presents the perceptions of the employees on the "contractual employment" of hospital staff, and its dynamics within a hospital system.

III. Perceptions on Characteristics and Dynamics of contract work in a Hospital setting.

i. New Recruitment Forms and their undefined conditions

The recruitment of hospital staff which is not on permanent basis first began with ad hoc placements. The system of ad hoc recruitment was in practice much before reforms. It was usual practice to tide over the time taken by the services commission in completing the recruitment

process. The ad hoc person was usually inducted for a fixed period, and this could be extended if the need persisted. The ad hoc appointees were paid the full scale of the post for which they were recruited. They were equally entitled to leave benefits including maternity leave, overtime, other allowances, medical cover etc. until they were in service. However there was no pension, or any long term job security.

While the adhoc rules did not confer any right to getting regularized, the interviews with doctors revealed that a large number of ad hoc appointees became permanent in due course. Although there was no written rule for such practice, but selection committees gave preference to existing employees, if they fulfilled all other minimum criteria. Delhi government doctors recruited on ad hoc basis were benefitted when a new cadre called Delhi Health Services was created, after the capital city was conferred partial Statehood. Almost all ad hoc doctors, who joined Delhi government in 1996 ad hoc batch got regularized through this change. But even for other posts in public hospitals, which were not related directly to health services, say like a Junior Engineer, the experience shows most ad hoc employees became regular when permanent selections were done.

However this system was gradually replaced by contractual recruitment of staff since 2000. Here the government directly recruited an employee for a contract of 11 months, at a fixed monthly payment. The system of contracts carries no allowances, or additional benefits, or security cover. Even the number of leaves is far less than those available to regular staff. In the interviews conducted by the researcher it was learned that the first batch of contracted staff came in the year 2003. And since then contracting employees has become regular practice. The general perception of contract work is very negative. One of the permanent doctors, who has also worked on contract in the past shared that – "*the contract system is abusive. There is nothing for the*

employee – no quota of leaves, dismal salary structures, and no long term plan or future scope. I used to be very depressed until I was working as a contract. I was so uncertain about my future – how long I will continue like this, or what will I do if someday my contract is not renewed."(Faculty working as Assistant Professor)

The lack of knowledge on how long the system of contracting would be practiced - will be it discontinued; or how it would be terminated, was a source of dilemma for all contract employees. In the private sector, private contracts are the normal form of recruitment, and all staff is employed under the same contract rules. However within the government, this system remained less understood – whether it was a temporary measure, or how long the system of contracting would be done. And what will be fate of its employees?

The system of outsourcing was implemented in two forms - first, a category of staff was recruited through a private contractor or agency, and then deputed by the contractor in the hospital. This is termed as 'contracting – in'. In the hospital selected for study, only the nursing orderlies were appointed through a contracting agency. In the second form of outsourcing, certain hospital functions were altogether outsourced. In the hospital, the functions of a cafeteria, laundry, cleaning and sanitation services, security services, were outsourced. This system is termed as 'contracting out'. The persons required for fulfilling these job roles are consequently appointed by the contracting agency, who fixed their salary and terms of contract. The government plays no role here, apart from conducting inspections in order to see if the contractor is fulfilling quality standards, and following all processes. In my interaction with the outsourced cleaning staff he shared – "*our system is different from government employees; we have been kept here by the contractor. He gives us the salary. But we report to the sanitary Inspector of the*

hospital. We get very few leaves, sometimes the contractor tells us to go even if we have health issues, saying he will keep someone else if we take too many leaves." (Outsourced cleaning staff)

ii. Discriminatory and Dismal Wages

The system of adhoc appointment was considered very fair by the respondents as the employee was paid the full scale of the post for which he was recruited. This was regardless of the number of years the incumbent served. So, although there was no job security, but the probability of becoming permanent was higher, and this had a positive effect with the people. But many times, adhoc employees who later became permanent found themselves at a loss, as they began from scratch in the hierarchy, and this affected their salary scale and promotional aspects. In many cases, the employees had to file court cases against the selection board, requesting for adjustment of their years of service as an adhoc.

In sharp contrast, the remuneration scales of contract staff was very less when this system was initiated. Often it was less than half of the basic pay which a permanent staff on the same position would draw. One could draw parallels with the salaries paid by private hospitals to its staff, however over the years, and with the coming of pay commissions these scales have been revised for few groups.

Taking the example of staff nurses, when contract nurses were first inducted their salary was fixed at INR 6000 per month. This was later increased to INR 11000 per month, and finally to INR 16000 per month. However when a large number of staff workers on contract basis united, they filed a case against the discrimination by Delhi Government between permanent staff and contracted staff, and made the demand for "Equal work for equal pay". This was premised on the

logic of same quantum of work being done by contract staff as permanent, while differential salary was being paid. In a landmark judgment, the contract workers won their demand in October 2016, and their monthly salary was increased to par with basic salary of permanent staff, which is now INR 45000. According to the court order – "*An employee engaged for the same work, cannot be paid less than another, who performs the same duties and responsibilities. Certainly not, in a welfare state. Such an action besides being demeaning, strikes at the very foundation of human dignity*". (The-Times-of-India, 2016) This has led to a significant boost in morale of contractual staff, and was even appreciated by permanent employees. These contract workers included staff nurses, and few sections of technical staff. However other postulates of the contract, i.e. a fixed term for 11 months, no allowances, no pension, leave disparity, etc. continues.

In the case of doctors, the present remuneration of contract assistant professor is INR 63000 per month. However this amount is regarded highly unjustified, as Senior Residents who are completing their Masters within the same hospital are getting close of INR 1 lakh per month. So someone who has already completed Senior Residency tends to get much lower pay than the students whom he has to guide and oversee. This acts very detrimental to the morale and confidence of the contracted doctors, and results in very few contract doctors sticking to their posts. It was reported that contract hiring does not solve the problem, as contract doctors leave these jobs as soon as they find a good job in the private sector.

Third, there were still certain sections of contract employees who did not come under the ruling of "Equal work, equal pay", and are still getting a very low monthly salary. One of these groups is 'Medical social worker", who gets a consolidated INR 15000 per month. The Medical social workers feel highly discriminated, because they are the only specialists who have to hold a

masters degree, and are paid such a low remuneration. Other technical groups often only require a diploma or sometimes a bachelor's degree in their specialization, and are getting a much higher scale. So there was no parity between the educational attainment of the incumbent and the remuneration paid to them. There were just two contract social workers in the selected hospital, and one of them said "*I am merely continuing in hope of getting a better salary sometime, or if god wills maybe becoming regular*." (Contract Social Worker)

However, for the outsourced workers, the monthly wage is decided by the contractor, and was found to be very less. It could not be compared to the scale paid to regular staff. The government here pays a fixed monthly amount to the contractor which is decided through the tendering process, and then he provides the human resources at a salary fixed between him and the worker. This makes room for much of discrimination and human right violation, as there is no social security, or even a job contract. The contractor can replace a worker any time, delays payment of salaries, and often the terms of work are very strict and salary paid is very low. Their vulnerabilities and exploitation are demonstrated in this episode shared by the outsourced cleaning staff. For many months the outsourced cleaning staff of the hospital was not given salary by the contractor, as the contractor had himself not received his payments from Delhi government. When the delay in government payment went longer, the contractor made all outsourced employees write and sign on paper, that they will get a salary only if the contractor receives his payment. And in case the contractor does not receive any payment, the workers will not demand from him any money for the services they have rendered. As a fallout, many outsourced workers left the job. Later, the contractor received his payments, and he paid his workers who were continuing, but cut the salary of those who had left the job. They were not

hired subsequently, as by then the contractor had hired new workers. Thus, they lost the job altogether. (Reported by Outsourced Cleaning staff who lost the job)

Thus, between the two systems, contract employees are more secure, as they are directly appointed by the government, and harassment is much less in comparison to outsourced staff, which faces ill-treatment and harassment from both the hospital staff and the contractor.

iii. Disproportionately Greater Work Load

Despite difference in remuneration and nature of contract, all contract workers are expected to do the same work which their permanent counterparts are fulfilling. Taking the example of staff nurses, a contract staff nurse can be posted in any of the departments where permanent staff nurse is posted. Qualification wise, both contract nurses and permanent nurses have the same or equivalent qualifications. Often contract staff nurses have many more years of work experience in the private sector. And most teams are a mix of permanent and contract nurses, who work together, and both report to the senior nurse posted in that work station or department.

However, in practice the scenario changes considerably. Interviews with nursing staff brought to fore an antagonistic relationship between contract nurses and permanent nursing staff. The contract nurses faced an unusually greater work load, because permanent staff would leave their share of work for them to fulfill. According to one of the contract nurses, most permanent staff keeps itself more occupied with administrative work, and they leave patient care upon contract nurses. One of the contract nurses said, "*Since our jobs are not secured, we cannot say no to any task. However, permanent staff nurses have no fear of anyone. They conveniently ask us to take care, while they do their personal work. And we can't even complain, because we fear if our*

report shows negative reporting, our contracts may not be renewed next time." (Contract Staff nurse, IPD ward)

Since the permanent staff had secured jobs, they don't fear anyone. Whether or not they performed their duties, punitive action was seldom taken. Rather the senior administrators feared taking action against them, as shared by the sanitary inspector – "*if I take punitive action against even one of the permanent cleaning staff, the next day their entire union will be up against me, and then no staff will work. So I have many workers who I know will not be doing work, but I have to deal with them very politely to make them do their jobs*." (Sanitary Inspector) In such scenarios, the contract workers face the heat, and had to often bear disproportionately greater burden. The permanent staff would make use of the vulnerabilities of contracted staff for transferring more work on to them.

However the scenario of teams in an Intensive Care Unit (ICU), or Comprehensive Care Unit (CCU) were different. In an ICU attached to the neurosurgery Operation Theatre, both contract and permanent workers felt they were overworked, as the ICU was functioning with less staff. From staff strength of 64 in 2010, they were down to 24 in 2017, as the ad hoc employees had left, and no new recruitment had been done. Interviews with three contract nurses from this ICU found that all staff members had to work round the clock, and there was strong cohesion between them. Permanent staff was also very appreciative of contract staff, and shared that we all have been managing the work despite the acute shortage of staff. In another such experience, at a CCU attached to the Cardiology department, the nursing staff was found to be overworked. While the stipulated norm of patient nurse ratio for CCU is 1:1; however here 5 nurses were taking care of 13 patients. In both these cases, the responsibility of patient care was very critical, and both contract and permanent staff were seen facing extra work burden. Such a scenario saw better

relations between them, in contrast to a ward or any other department. The continuous presence of senior doctors in these units disallowed any scope of malpractice by lower staff, and each one was answerable.

For the outsourced staff, the areas of their operations have been separated from permanent staff in the hospital selected for the study, and hence their interaction with permanent colleagues is less. One of the hospital's main building where all OPDs take place, is a recently constructed building which by model has been designed to use the services of all outsourced staff. The sanitary inspector said the contractor hired less number of workers than were needed for the area under them. This led to outsourced workers working for longer hours than their permanent counterparts. He said the situation was much controlled due to physical demarcation of their area of work; otherwise the permanent staff would have made the outsourced staff also do their share of work. Functionally the outsourced staff reported to the sanitary inspector in the hospital, but for his salary and leaves he had to report to the contractor. The disillusionment with the system of employment was immense with both the outsourced nursing orderlies (NOs) and cleanliness staff. The NOs complained that the nurses transferred even their responsibilities like changing of bed sheets, measuring urine levels, or changing the urine bag, or even the wrapping of dead bodies. One of the NOs who had immense loathing for nursing cadre said – "*they are responsible for the declining standards of care. Because the government had increased their pays, they feel they have become too superior for these tasks*." (Nursing Orderly, Outsourced)

The responses for all doctors, nursing staff and technical staff was more favorable of the outsourced cleaning staff, which was available at all times. While earlier when they dealt with permanent staff, they would have to make repeated phone calls to send a cleaning staff, and they would be absent from the job scene. Even the sanitary inspector, who manages day to day

cleaning operations of the hospital, said it was more difficult to take work from permanent staff. The outsourced staff knows they can be put out of job if a complaint against them is made, so they work better.

iv. Severed Interpersonal relations

In general the perceptions about contract staff were not very positive, and this affects their relationship with permanent staff. They are always seen as outsiders, and not as part of the system, and often excluded from social forums, and discussion groups, leading to their alienation. The contract staff is popularly characterized by permanent staff '*as feeling temporary placed, that they don't belong here. Today they are working here, tomorrow if they find a better job, they will go there*". (Permanent staff nurse) Since their jobs are not permanent, they don't develop belongingness with the hospital. In contrast, the permanent staff knows he/she has to work here only, so they become much more attached to their work place, and more involved. In the dietary department, there are seven Assistant Dieticians who are all on contract, and the unit is headed by a permanent Dietician. She felt that the attitude of contract staff was very casual. "*They just do the work, not bothering about how the work is being done, and don't pay much heed to suggestions being given about doing things in a better way*." (Dietician, permanent)

Another characteristic associated with contract staff is "*they are not dependable*", whereas permanent staff is very responsible. One of the senior nurses noted - "*The contract people would take leaves anytime, without regard of how a work station would be managed without people. Since they have very less leaves, they have become accustomed to foregoing their salary, and so it makes no difference to them, and they take leaves anytime*". (Sister in Charge)

There is also a feeling of superiority, which permanent staff feels over contract staff, even though they may be working at the same post. They expect to be treated with respect by the contractual staff, and comply with what they tell them to do. The permanent staff extracts its superiority in having undergone a stringent and competitive recruitment process, and then getting selected. In contrast contract recruitments have fewer formalities to be completed, and a mere interview is done for selection. The same was shared in another inpatient ward, where the senior nurses were against the system of appointing contract staff. She shares, "*I always request my seniors not to post contract staff nurses in my ward, as I find it extremely difficult to take work from them. Not all, but some of the contract nurses are not even trained from proper institutes and are carrying fake degrees, and they learn most of the things at job. This compromises quality*". (Nursing Sister, Private ward)

Since all senior nursing staff is permanent, they are seen enjoy a better rapport with permanent junior staff. Their view about the contract nurses was also not encouraging. One of the Nursing Sister shared "*We cannot leave the responsibility of handling high end equipment with contract persons as we have found them very callous in their approach. Since the accountability for all stock and machines lies with me, I have to be careful in distributing work. I can be questioned if anything goes wrong. They have nothing to lose, their jobs are already contractual*." Since promotional avenues are reserved for permanent staff, there is a strong notion that only the permanent staff member will continue here in the long run. As a consequence, senior staff nurses attach greater credibility with permanent junior staff.

So mini empires or multiple hierarchies have been created within hospital wards, departments, where all the permanent staff emerges as one solidarity group. While the contract persons are left to fend for themselves. The contract staff often lacks this solidarity as a group, and they are

unable to trust other contract staff, especially if they are close to the permanent staff. There is a constant fear of negative reporting, even from fellow contract colleagues, and this makes them very lonely. "*I can't talk to any of the nurses in this way I am talking to you. They don't spare any chance of complaining about us, and becoming good in the eyes of seniors*." (Contract staff nurse)

The dynamics of interpersonal relations vary with different occupational groups. Among the doctors, there is absolute disenchantment with the system of contract hiring of doctors, and the remuneration is seen highly inadequate. They not only feel it is discriminatory, but also counterproductive as doctors hired on contract never stick to their jobs, and use the experience of working in a public hospital for finding a more rewarding job in the private sector. This acts negatively for the department because by the time the faculty trains the contract physician and starts depending upon his/her services, they leave their jobs. As highlighted earlier, contract doctors have a low morale with their salary scale is much lower than scales paid to Senior Resident (SR). They feel SRs don't give them as much respect, as they would give to a permanent faculty member. Even permanent nursing and technical staff does not treat them well. An interesting comment was made by a senior professor – "*if a contract doctor is sticking in the hospital for a long time, then you can understand he is not a well trained doctor, otherwise doctors with a sound background will find a better job very soon*" (Professor in the Hospital)

Contract nurses make up the maximum share of all contract staff in the hospital. Among the nursing staff, there was a lot of tension between contract and permanent nurses. The permanent staff shared many time in the past contract staff would simply refuse to fulfill certain duties, saying "*you do it; you are getting paid such a high salary*". This was much more at the time, when salary scales of contract nurses were very low. But ever since their scales have raised equal

to permanent staff's basic level, the contract nursing position has also become very lucrative, as no hospital in the private sector pays a salary of INR 45000 to even a senior nurse. As a consequence, now the permanent employees have turned oppressors. They now know that most contract nurses find their jobs very dear, and cannot fear losing it. So they quietly put all the patient load and unattractive features of their jobs for the contract nurse. As one of the contract nurses shared - "*ultimately they will write our report, on the basis of which our contracts will be renewed. And so we always have to maintain a positive image. We cannot deny any work they give us because we cant afford to lose this contract. So they simply roam here and there, go for tea breaks for one whole hour*." (Shared by Contract staff posted in IPD ward)

Among the technical staff, this relationship was less intense. Here the problem was more of quality and attitude of contract staff. A large number of technicians and laboratory staff have been hired on contract. In the blood bank, the permanent staff shared that the contract person did not behave well with patients, and if the patients go and complain, we have to answer to the administration. A lack of sincerity was often pointed out in the attitude of contract staff, but otherwise coordination was better. Overall, the permanent staff feels very sorry for contract employees, and there is a strong sense of sympathy for contract workers - that despite doing so much work, this contract employee may never become regular. Most permanent staff was unhappy with the government's system of contract hiring, and was of the view that it should stop, and permanent staff be brought, which would be more confident, better trained and more motivated to work.

Even among the permanent cleaning staff, their opinion of outsourced workers was very bad. Their quality of work was pointed out to be very poor, and they were reported to be untrained for cleaning requirements of the hospital. They were also reported to indulge in petty crime, like

stealing mobile phones of patients or staff. The nursing orderlies felt exploited because they did technically superior work, however they were treated at par with the cleaning staff. They demanded their pays be also made at par with permanent nursing orderlies, and discrimination between different categories of workers was unethical.

v. Job Insecurity and Poor Prospects of growth

The contract staff has been hired only at the junior most level or position for all staff groups. And as per their contract, there is no scope of any promotion or increase in salary during the course of contract. As a result, contract staff has been working at the same post at which they were hired. Many of them have been posted at the same workstation or ward, or OT for the last seven to ten years. As shared by contract nursing staff, they have become trapped in these jobs, because financially this is the most rewarding job for them. If they move out, the private sector pays very less. And so, they are gradually becoming very timid, as these jobs are very dear to them, and they can't afford to lose them. In the words of one of contract nurses – "*I am constantly reminded, rather conscious of the unsecure nature of my job, and worried what will happen if I lost this. I want to become regular whenever UPSC will recruit. But the postings rarely come.* (Contract Nurse). Since there is an age limit for permanent selections, the contract staff feels trapped, and this gradually leads to frustration for contract nurses, who are unsure of their long term job security.

The same ethoses were shared by contract technicians, who also get paid salaries at par with permanent technicians. They say - "*see what is the option for us now. It is the privates sector. And no hospital in private sector will pay us this scale. So we are happy here. We are able to serve the poor of our society. Also there is less exploitation here in comparison to the private*

sector." When asked about what will happen if their contract is not renewed, the contract staff shared that this question is always lurking in their minds, but there is no solution. The sense of job insecurity is immense, and a constant source of stress for the contract employees. "*We apply for permanent position whenever it is advertized, but these are very few, and you need a strong jack to get selected*." (Lab Technician, on contract)

Few contract workers also live in the hope that their service as contract may make them more favorable for selection whenever permanent recruitment is done. However there is no such written or spoken commitment from the government. The contract doctor in the hospital was very frustrated. She says – "*I don't know how long I will keep working like this. The government does not clarify its position on contract staff. They just keep renewing our contract*." On asking why she didn't consider joining the private sector, she replied – "*may be they will regularize me one day*". (Assistant professor, on contract). Such an expectation, to be made regular, stems from a history of regularization of ad hoc doctors in Delhi in the past. However, the system of ad hoc appointments was different from contract hiring. And according to few senior staff members, the system of contract appointment, as against ad hoc was introduced only to ensure that the applicant could not put pressure on the government for making them permanent.

IV. Implications for the organizational culture and service delivery

The hospital has benefitted immensely with the recruitment of contract staff. This is because owing to the extensive delay in regular appointment, a situation of acute staff shortage had developed, and this not only put a lot of pressure on existing staff, it led to delays in completion of responsibilities, and compromises on quality. So the intake of new staff, even though on

contract, has alleviated the crisis of missing staff members that was inflicting the hospital and even in other health institutions. Although most hospitals still fall short of the sanctioned staff strength, but the infusion of a significant strength of contract employees has strengthened hospital systems, allows better coordination of activities, improved the morale of existing employees, and facilitated better management of excessive patient load that most public hospital endure.

However the induction of employees on differential contracting terms has led to a fragmentation of authority and accountability systems; created operational problems in governance; developed a workforce with very low morale and high sense of alienation; and sowed distrust between employees, all of which have a negative bearing on the quality of work and for the organization culture of the hospital. The two groups –contracted staff and outsourced staff, are constantly comparing themselves to the permanent employees, and finding faults in their way of working, and feeling victims in the system. They lack a sense of belongingness to the institution, and their sense of alienation is very strong. *Poor working conditions, psychosocial pressures, less autonomy, lack of safety and protective measures, lack of social dialogue and inter-individual collective and economic and emotional insecurities arising out of the casualisation of jobs occurring in the informalisation process has important fall-outs. It decimates the quality of life of the workers with poverty, ill health and miseries and it also affects the system.* (Thressia, 2016)

MULTIPLE HIERARCHIES and GOVERNANCE Issues: Each permanent employee starts acting as an authority over the contracted staff. Since there are no rules for the protection of contract staff, or no contract staff at senior positions to speak for them, their accountability lies at

behest of permanent staff, who were found to be biased in their opinions about contracted staff. Functionally the authority becomes distributed till the lowest levels, and its abuse becomes easy. Even a permanent staff nurse can dictate rules and duties to a contracted staff nurse. For most of administrators, they depend on the reports presented by other permanent staff, and have no way of ensuring that these are not biased. Thus, the induction of contract staff creates day-to-day problems in governance. And authority is seen distributed to even the lowest of positions.

However, the outsourced staff in contrast to contracted staff faces a double whammy as they have to report both to hospital administration and the contracting agent. Constant and strict surveillance; humiliation by permanent staff; and insults by their supervisors publicly even for minor mistakes eroded their capability to render efficient work. As Thressia writes – *introducing unequal labour standards and dividing the workforce within an organisation and the system threaten the concept of building an integrative, social development oriented workforce and health development*, once envisaged by Alma Ata. (Thressia, 2016)

FRAGMENTED AUTHORITY AND ACCOUNTABILITY: The management of outsourced work becomes very tedious as functionally hospital administrators have to bear the responsibility of ensuring work is done, however they lack any authority over the staff or the contractor. This becomes very difficult for supervisors to enforce any action. There were reports of contractors' preoccupation with minimizing expenditure that led to poor quality of work; however the supervisors lacked any authority over these aspects. Both the Sanitary Inspector and Laundry Attendant, who have to oversee the everyday sanitation and laundry services in the hospital, had immense problems in dealing with outsourced staff. They both shared that work does happen, but if you questioned about the quality of work, then little could be done about it. The sanitation

contractor has to supply cleansing detergents, which were reported to be highly diluted, but inspection of these aspects was rarely done. So 'quality' gets diluted, even though work gets done. The sanitary inspector could raise these issues with the contractor, but rarely any steps were taken by him to improve.

The laundry attendant also shared that he would raise alarm on each stain that was left on the bed sheets or towels, and discuss with the contractor. But apart from raising concern, he could not to do anything. His impression was of severe quality compromises, and he feared infections were not getting properly removed. He shared – "*earlier we used to do all these things on our own. I know that these sheets are not being boiled as long they should be, otherwise these stains won't show. But I can't do much*." (Laundry Attendant) As Baru writes – Poorly qualified and paid persons are hired as paramedics to contain costs and for maximizing profits by private enterprises that further erode the quality of care (Baru, 2004)

DISTRUST among staff: The contract staff, despite getting a salary at par with permanent staff, feels they have to bear an un-proportionately more work burden, and discrimination from permanent staff, who have secured jobs, and they don't fear from anyone. Numerically, since permanent staff is greater, their unity often becomes threatening to the contract employees, who are unable to trust their counterparts. They fear if anyone complains about them, their contract may not be renewed in the next cycle, which is something they cannot afford. Even the senior most people in the hospital, like the Head of Departments, or Nursing Superintendent hold the permanent staff in better image and between the contract and permanent staff has higher faith and trust on the permanent employee. In such an environment, the chances of the contract worker getting a fair say in any matter is very bleak. The contract worker performs his duties with

constant feeling of being replaceable. Because the level of unemployment in the market is significant, there is a log queue of people desiring to get recruited on contract in the government hospitals. The vulnerability of contract staff makes them more amenable for discrimination and abuse. Many among the permanent staff have a sense of superiority over the contract staff, and constantly transfer their share of work upon them. This intensifies the divide, and contract staff label most of their permanent counterparts as leeches on the government system, who only take high salaries but would not do any work. In such a scenario, mutual respect is completely eroded. The morale of contract staff is very low, and they are unable to develop belongingness with the hospital or their job or colleagues.

DISASSOCIATED workforce: The attitudes of contract and outsourced employees, their speaking manners, and casual attitudes were reflective of their low sense of belongingness to the hospital. The lack of we feeling, and a lack of association to one's work, ultimately resonates in their capacity to deliver, whereby the patients have to endure a negative experience. "The processes of informalization and resultant pathologies in the system reflect in the services provided. The quality of services in responsiveness and patient provider relationships are severely compromised" (Thressia, 2016)

One of the trade union leaders shared how this had maligned the hospital environment and leads to bad experiences for the patients. He says – "*when a patient comes to the hospital, he is often unaware about where to go, and how to make a consultation. But who is the first person they will encounter, it is the hospital guard. The way the guard responds to the patients is often very demeaning. They will just make the patients unclog an area, without guiding them where to go. For the patient or his relatives, who are already reeling under some medical crisis, having such encounters makes the hospital experience very unfriendly. At a tertiary hospital, most of these*

patients are suffering from severe advanced stages of diseases, and reach here after treatment failed at other lower facilities or could not be sustained in the private sector. They endure so much discomfort before they are able to consult the doctor, or avail any services, and lose trust in the system. And they carry this image for all employees of the hospital – that all are alike." (Technician and Trade Union Leader)

He further explains that one can't even blame the guard, because the outsourced security guards have not been trained for the hospital environment. "*For them, it is just like any other workplace. One day he is placed by the agency in a bank, then someday in the factory, and someday in the hospital. So the empathy with patients is absolutely missing in his temperament. He will be very efficient in his work, you can see there is no patient near the administrative department. But how he will deal with people remains an issue. You can tell him to be polite, but ultimately their training is very different."* (Technician and Trade Union Leader) So the training and orientation of outsourced staff was pointed to be unsuited to the hospital environment.

In another instance the lack of interest of the contractor was even noted. The hospital staff has to often bear with improper vocabulary of outsourced staff, or misbehavior, however many times when the contractor was asked to intervene, his approach is also seen to be very casual. In one case, the Nursing In-charge of a private ward was facing problems with the attitude of the laundry boy, who would not speak properly or reply to her problems. When the nursing in-charge complained about it to the contractor, he replied – "*why is it that you only have problems with him? No other person has a problem with him*." (Laundry Attendant)

WEAKENED TRADE UNIONS: The induction of staff through different contracting terms has also caused a serious blow to workers solidarity movements. Most hospital staff comes under the cover of any one of the registered Trade unions, which have been very strong in voicing out the concerns of their members, and demanding adequate protective measures from the government. Problems relating to promotions, salary hikes, work timings, etc. were raised by the union to the government, and often strong workers strikes in the past put pressure on the government to take serious consideration of their demands. However, with the entry of contracted staff, the traditional unity of hospital staff is weakened considerably. Earlier strikes by staff members meant that that not a single staff worker from that union would join work. However now, the government is able to make the contract workers continue to work in case of any strike, because these workers fear the loss of their contractual jobs. So the workers solidarity movement has suffered a big blow. With the increasing induction of employees on contractual arrangements, their membership has started to decline. And they are unable to exert pressure on government for their demands.

V. Conclusion

The recruitment of health workers through contracts and outsourcing agencies has become the norm for the public health sector in India. With the initiation of National Rural Health Mission, a large number of health workers including physicians have been recruited on contract across the country. This has pushed a huge segment of workforce into casual or informal work. For workers at the end of the hierarchy these processes have exposed them to exploitative terms of work, and significant human rights violations. At all levels, from primary to tertiary permanent inductions

have been slowed down, and these are being fulfilled by informal employees. This process of casualization of workforce is seen to increase workers insecurities and creating a non conducive working environment where the workers are unable to work productively, and on the contrary, witnessing psychosocial stress and increased vulnerabilities. These virtues significantly restrict the capacity of a worker to provide quality services, and satisfying patient needs.

The system of contracting is also fraught with ethical concerns, where there is very less transparency about system of tendering contracts and outsourcing. Even the contracts themselves have many ambiguities, which create space for abuse and human rights violations. In many cases, the outsourcing agencies were found to be violating even the minimum wages stipulated by the government. The fragmentation of workforce has led to fragmentation in authority and power of the public institutions to control quality of service and care to patients.

The experiences a patient and his relatives have at the public hospital are greatly determined by their interactions with hospital staff and cooperation extended to them. And these are in turn influenced by the morale and mental state of health providers. A workforce symptomatic of poor incomes, job insecurities, work alienation, lacking social participation, and distrust on the system can rarely provide healthy and quality care to patients. The system of contracting thus poses immense threat to patient's rights to quality care, and compromises on the organizational culture of public health institutions.

In the process of casualization the public health sector "*is loosing its 'public ethos'*". Instead of acting against the exploitative and discriminatory human resources policies of the private sector, by emulating these pathways it has created space for their justification. This has severe repercussion for worker's access to fair wage and proper working relations. As Thressia writes –

"*Public services are not simply services provided by government-owned facilities, but the expression of a responsibility of the government towards the public that is expressed through the provision of these services*". (Thressia, 2016)

The Indian government needs to look into the issues posed by the system of contracting labour, and devise strategies to safeguards the interests of workers and prevent their abuse. Investments in health workers are ultimately investments in good quality health services, and any compromise will only lower the standard of public health services. The system of contracting needs to be addressed for its ambiguities, and to protect the workers from abuse and exploitation. Regular inspections of outsourcing agencies and punitive action for failing to fulfill contract conditions must be enforced. Quality and standards of care need to be defined, and its adherence needs to be enforced. All these are the responsibilities of the government, not just to the health care workers, but to people's right to quality healthcare.

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