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CASUALISATION OF THE HEALTH WORKFORCE AND EROSION OF TRUST IN PUBLIC HOSPITALS

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Abstract

This paper seeks to examine the casualisation of the work force and its consequences for work relations in public hospitals. Casualisation of the health workforce was an important initiative of health sector reforms but there is little conceptual and empirical work on the process and consequences for the functioning of public hospitals. The paper critically engages with the ideological justification for casualisation, the different forms of casualisation, the effect of casualisation on work relations in public health institutions.

The first section of the paper defines casualisation of work and its ideological roots. It locates it operationalization within the agenda of health sector reforms informed by the tools of New Public Management. The second section highlights the various forms of contracting systems that have been introduced in public hospitals across the work hierarchy. Based on an analysis of existing studies, indepth interviews and observations this section highlights the importance of a systemic view to understanding the working relations in a hospital. The third section focuses on multiple forms of contract arrangements within the public hospital and the potential for role conflict and duplication. It further argues that these contract arrangements lead to alienation of workers at an individual and

collective level. This has serious implications for interpersonal relationships that have a bearing on institutional values and behaviour. The last section highlights the consequences of casualisation of the workforce for functioning of public hospitals. It argues that the process of casualisation of public hospitals leads to weakening the solidarity of workers which is essential for a team approach for delivering preventive, curative and rehabilitative services. The weakening of solidarity leads to erosion of trust among health workers that in turn has serious implications for patient care.

Introduction

The health service system is a complex of a several sub systems that include financing, provisioning, human resources, drugs and technology, education and training of personnel and research (Qadeer: 1985). Among these sub systems it is financing and human resources that form the backbone of the health service system. Human resources in health can be seen a complex network of relationships consisting of skills and social interactions. Its arrangement is hierarchical with a clear definition of roles that complement each other. The interaction between and across different levels of the work hierarchy results in a team approach within the health service system for the delivery of preventive, curative and rehabilitative services. Health service systems are not restricted to

only a technical role but can be conceptualized as a human service organization (Hasenfeld: 1992). The attributes of a human service organization are premised on the understanding that the encounter between health personnel and the person seeking care is a series of human interactions. Also for those receiving care, human service organisations must embody the values of trust, care, commitment and responsiveness to human needs. However, the relationship between providers and those receiving care is mediated through power. It is the former who set the terms for the encounter with the latter through their attitude and behaviour.

Behaviour of providers is an outcome of individual, institutional and societal factors. Bennet and Franco (1999) conceptualise this as the interaction of several layers to include individual level determinants; work context level determinants and determinants that arise from interaction with social and economic contexts. Changes at all these levels could significantly influence the attitude and behaviour of providers.

Health sector reforms and changes in work relations

In recent times the most significant policy intervention has been the introduction of health sector reforms informed by new public management, for promoting efficiency and efficacy in health services. It is now well recognized that the introduction of new public management tools in health services resulted

in far reaching changes with respect to financing and human resources in developed and developing countries. While there is substantial writing on the changes that were brought about in financing of health services, little attention has been paid to human resources in health.

A few important studies on planning for human resources in health have mapped the availability, distribution and shortages of the different categories of health workers in India (Anand and Fan:2016; Rao KD:2012; Rao et al: 2011). KD Rao's study provides insights into the gender and sectoral distribution of health personnel. His analysis shows that women dominate the middle and lower levels of the work hierarchy while among the doctors it is the reverse. It also shows that 70 percent of the health workers are in the private sector that includes both the informal and formal. Anand and Fan's analysis also shows the inter-state and rural-urban variations among different levels of health service personnel. It also shows the variations in the availability between allopathic and non -allopathic practitioners.

A broad summary of all these studies demonstrates the shortfall and gaps within and across categories of health workers across states in India. The shortages and gaps in availability of health personnel, have an impact on the overall functioning and responsiveness of public health institutions. An analysis of the various rounds of the National Sample Survey on utilisation of health services shows that

majority of people do not access public services for outpatient and in-patient care. The reasons for not accessing public services are due to lack of medicines, personnel, distance, expenditure and rude behaviour of staff. Clearly, availability, accessibility, affordability and acceptability of health services are important determinants for utilization.

For both availability and acceptability of health services health personnel is the key. The shortages and gaps in availability of human resources in the public sector is a key concern. Not having a full complement of the required staff makes an institution dysfunctional. Whenever there are shortages, the work load increases for the existing staff and in some cases state governments have experimented with multiskilling of existing personnel. Alternately, shortages are filled with temporary or contract staff. At present many state governments in India are increasingly resorting to contract staff to fill vacancies. The crisis in availability of human resources coupled with health sector reform initiatives has fundamentally changed the landscape of employment pattern and practices in the public sector. What was once only permanent employment for all levels of staff, has now undergone many changes through the process of casualisation of work. Over the last two decades casualisation has become popular with several state governments for hiring health personnel.

There are very few studies that address the restructuring of terms of work and relations in the public health services. Several initiatives were introduced into the health services in high, middle and low income countries. These ranged from retrenchment, casualisation and incentivisation of health workers at different levels of care. While we do not have very reliable figures on the number of casual workers in the public health sector, some estimates indicate the rise of informal work between 2004-05 and 2011-12 in the health sector. The data shows that the percentage of regular and informal workers without a written contract has increased from 47 percent to almost 50 percent in the health sector (Srivastava: 2016).

Health sector reform and casualisation of health workforce

Defining Casualisation

The health sector needs a varied skill mix for effective patient care and is therefore dependent on a large work force to deliver care. The health sector reforms that were informed by ideas of New Public Management, sought to improve the 'economic inefficiencies' of the health sector by recommending casualisation of work as a means to cut labour costs since salaries contributed to a substantial part of the public health expenditure. 'Flexibility' was introduced in the labour market through three means –employment flexibility; wage flexibility and functional flexibility. All these three were also introduced in the health

sector. Employment flexibility refers to the freedom for the contractor to determine employment levels quickly and cheaply, wage flexibility refers to the freedom to alter wage levels and functional flexibility refers to the freedom to alter terms and conditions of work (Cheadle:2006). This resulted in the contracting out of the unskilled and semi-skilled jobs in the non-clinical services. The terms of contracts were varied- short term; fixed term contracts and daily wage payments. As a result, multiple forms of work contracts were introduced within the health sector.

The first wave in casualisation of health workers was restricted to contracting out of non-clinical services like laundry, diet, cleaning and maintenance. These workers occupied the lower rungs of the work hierarchy. Those who occupied the higher rungs of the work hierarchy perceived it as a more cost efficient and effective measure and thus welcomed the casualisation of labour for these services. The view from below was however diametrically opposite. Studies from the developed and developing countries show that the relationship between the contracting authority and the worker was seen as exploitative (Society for Labour: 2007). Gradually, newer recruits to the medical and paramedical categories were also being hired on a contract basis. This resulted in a mix of permanent, contract and casual personnel across categories of the health workforce.

Roy's study describes the newer contracting arrangements in a public hospital in Kolkata, West Bengal. She observes that there are different types of contracts that exist within the same hospital. Based on interviews with contracted workers she highlights the insecurity and powerlessness they feel in the existing conditions (Roy: 2010). Interviews with contract workers reveal that they are poorly paid and are exposed to long hours of work and are not given minimum protective measures. Similar observations have been made by Bisht regarding the plight of contract employees in a hospital for the treatment of tuberculosis in Mumbai. She highlights the vulnerability of workers who handle the disposal of bodily wastes of patients in the hospital. They are not supplied with protective gears nor with any social security if they were to acquire infections relating to their occupation. The study highlights the callous attitude of the contractors and hospital staff towards this category of workers (Bisht: forthcoming).

The differential working conditions within a hospital is linked to the myriad forms of labour contracts that exist within it. There is a great deal of variation in these contracts depending on the contracting agent. The contracting agent can be government or private depending on the nature of work. There is much variation in the terms of work, pay and benefits that workers receive. This results in several contradictions and conflicts amongst workers within and across categories. Indepth interviews with senior doctors cum administrators from a

public hospital in Delhi highlights the complexity of the contracting system and the variation in the terms and conditions of these contracts. These multiple contracts produce contradictions and conflicts within and across different categories of workers (Interview with senior administrator, Delhi; May 2017). They further observed that these multiple contracts fragment and undermine authority of the administrator within the hospital. As one of them observed:

"As a Superintendent of the hospital I have little power or control over the private contractors and the workers" (Interview with senior administrator, Delhi; May 2017). Clearly, the authority of the administrator is fragmented and weakened through the contracting of workers. This has far reaching consequences for building trust, commitment and motivation across the different categories of workers (ibid).

A recent study of health workers in the public hospitals in Delhi provides empirical insights into the type of contracts, the categories of workers that have been casualised and the consequences of contracting for the morale of workers (Society for labour: 2007). Based on the survey of 400 workers in public institutions she observes that:

"Two types of contract work exist: one that is contracted through a labour contractor and one that is directly on contract with the government. The latter is found mainly among doctors, nurses etc. (Society for labour: 2007). The table

below gives details of the hierarchy of work and the type of contract for each category. It is apparent from the table that the proportion of contract and daily wage worker increases in the lower categories. For certain categories like nurses there is a mix of contracting arrangements. For other levels of non-clinical staff the proportion of permanent workers is very small compared with contract and casual workers. Overall one finds that majority of health workers are either contract or casual workers who have replaced permanent workers.

Status of Work by Occupational Categories

Occupation	Contract Workers*	Regular Workers**	Daily Wage Workers	All
Doctors	2 (2.70)	72 (97.30)	0 (0.00)	74 (100)
Nurses	9 (17.65)	37 (72.50)	5 (9.80)	51 (100)
Pharmacists	0 (0.00)	19 (100)	0 (0.00)	19 (100)
Ward Boys	11 (34.38)	0 (0.00)	21 (65.63)	32 (100)
Ayahs	4 (80.00)	0 (0.00)	1 (20.00)	5 (100)
Sweepers	15 (28.30)	5 (9.43)	33 (62.26)	53 (100)
Cooks	2 (66.67)	1 (33.33)	0 (0.0)	3 (100)
Washermen	2 (12.50)	12 (75.00)	2 (12.50)	16 (100)
Drivers	3 (9.68)	5 (16.13)	23 (74.19)	31 (100)
Admn. Assts.	0 (0.00)	3 (100)	0 (0.00)	3 (100)
Security Personnel	45 (93.75)	0 (0.00)	3 (6.25)	48 (100)
Attendants	0 (0.00)	11 (52.38)	10 (47.62)	21 (100)
Store Officers	0 (0.00)	1 (2.86)	34 (97.14)	35 (100)
Electricians	1 (11.11)	8 (88.89)	0 (0.00)	9 (100)
Total	93 (23.25)	174 (43.50)	133 (33.25)	400 (100)

Note: *Figures in parentheses denote percentage distribution*
**Workers who are on contract usually have been getting their contracts renewed, giving the perception that they are permanent and regular when in fact, they are not.*
***Regular permanent workers*

Source: Society for Labour and Development. India's health care in a globalised world: healthcare workers' and patients' views of Delhi's public health service. Society for Labour and Development, New Delhi, 2007.

The terms and length of contracts also vary. Contracts given by the government are normally for a year. It is mostly private agencies that contract work for the other categories. The duration of the private agency contracts is normally for three to six months. The private agency led contracts are therefore very insecure for workers. The terms of work and working conditions gives rise to variation on perception regarding working conditions. The casual workers find the work not remunerative.

Perceptions on Present Working Conditions

Issues	Contract Workers*	Regular Workers**	Daily Wage Workers	Total
Not Remunerative	22 (26.00)	20 (24.00)	42 (50.00)	84 (100)
Unpleasant Environment	13 (45.00)	10 (34.00)	6 (21.00)	29 (100)
Health Hazard	1 (33.00)	2 (67.00)	0 (0.00)	3 (100)
Problem with Contractors	13 (100)	0 (0.00)	0 (0.00)	13 (100)
Other Problems	7 (64.00)	3 (27.00)	1 (9.00)	11 (100)
Satisfied	37 (14.00)	139 (53.00)	84 (32.00)	260 (100)
All	93 (23.00)	174 (44.00)	133 (33.00)	400 (100)

Note: *Figures in parentheses denote percentage distribution*
**Workers who are on contract usually have been getting their contracts renewed, giving the perception that they are permanent and regular when in fact, they are not.*
***Regular permanent workers*

Source: Society for Labour and Development. India's health care in a globalised world: healthcare workers' and patients' views of Delhi's public health service. Society for Labour and Development, New Delhi, 2007

Work hierarchy mirrors the social hierarchy

The work hierarchy mirrors the social hierarchy in health institutions. Gender, religion, caste and class intersect and get reflected in the work hierarchy. Majority of doctors are male, Hindu, upper caste and middle class. Nurses are mostly female, a mix of Christians and Hindus but belonging to lower middle caste and class. The workers belonging to the lower rungs of the hierarchy belong mostly to the lower caste and class (Baru: 2005). If we examine the caste and class characteristics of casualised workers they mostly belong to poorer socio-economic strata. This results in the compounding of vulnerabilities. Their vulnerability is due to the poor socio-economic conditions and weak skill base as casualised workers. The study of the social background of health workers in Delhi hospitals provides insight into the caste dimension of the different categories of workers in relation to the work hierarchy as shown in the table below.

Occupational Categories by Caste

Occupation	ST	SC	OBC	Others	Total
Doctors	12(16.22)	17(22.97)	25(33.78)	20(27.03)	74(100)
Nurses	17(33.33)	14(27.45)	9(17.65)	11(21.57)	51(100)
Pharmacists	3(15.79)	6(31.58)	2(10.53)	8(42.11)	19(100)
Ward Boys	10(31.25)	13(40.63)	3(9.38)	6(18.75)	32(100)
Ayahs	0(0.00)	1(20.00)	2(40.00)	2(40.00)	5(100)
Sweepers	14(26.42)	27(50.94)	7(13.21)	5(9.43)	53(100)
Drivers	10(32.26)	8(25.81)	9(29.03)	4(12.90)	31(100)
Security Personnel/ Chowkidars	14(22.95)	25(40.98)	16(26.23)	6(9.84)	61(100)
Attendants	8(22.86)	12(12.00)	10(28.57)	5(14.29)	31(100)
Others	7(17.95)	17(43.59)	28.21(94.00)	10.26(71.00)	100(100)
Total	95	140	94	71	400

Note: Figures in parentheses denote percentage distribution

Source: Society for Labour and Development. India's health care in a globalised world: healthcare workers' and patients' views of Delhi's public health service. Society for Labour and Development, New Delhi, 2007

Consequences of Casualisation

In order to capture the complex pathways of casualisation one needs to delineate the determinants at the individual, institutional societal levels (Bennet and Franco: 1999). This framework delineates the intersections and interactions between these levels and how it affects the motivation, attitude and commitment of workers, individually and collectively. These in turn have an impact on the culture, values and ethos of institutions. One could argue that casualisation of workers produces ruptures in social and work relations and

these affect the functioning of the institution. Benach et al (2010) have observed that casualisation of work produces a number of adverse effects. These include work tasks, working conditions, employment conditions and relations. Casualised workers work under poorer work conditions, lack safety measures, poor social dialogue with other workers, face economic insecurity and psycho social stress due to lack of job security which leads to a highly alienated and less committed work force. Etizioni (1960) conceptualised alienation of workers in psycho social terms. At the level of the worker, the terms and conditions of work have a deep bearing on the attitude, motivation and behaviour of workers. In the case of casualised work, the alienation of contract workers is palpable and leads to them being less included and involved in the organization.

We propose to argue that casualisation of work leads to splitting of cohesiveness, solidarity and trust among workers in a public institution. This could lead to multiple perceptions and interpretations of the values and goals of a public institution depending on the terms of work across the hierarchy. This fragmentation has an effect on behaviour of workers with one another and the patient resulting in the lack of a shared understanding of the idea of the 'public'. The idea of the 'public' is then instrumentalised into a series of transactions between providers and patients rather than an interaction that embodies shared values, trust and empathy that the latter expects when seeking treatment.

Casualisation of work and its effect on motivation and commitment

A few studies have highlighted the negative effect of casualisation on motivation of health workers. This is expressed by contracted workers in terms of insecurity of work, poor wages, lack of social security, overwork, lack of promotional avenues, fear of occupational related health risk and powerlessness to assert their rights (Thresia: 2017; Roy: 2010). Interviews with contract workers in a public hospital in Telangana highlighted the tensions in the relationship between the contract workers and permanent staff among the nurses (Field notes from Telangana, 2017). It was observed that the permanent staff exerted their power over the contract staff by demanding more work from them. The contract nurses were resentful but were fearful of losing their job if they protested. The permanent staff viewed the contract staff as dispensable and not committed to their work. Some even questioned their competence since they had not been recruited through a competitive selection process. Similar dynamics were seen at the lower levels of the work hierarchy and they felt much more vulnerable and resentful of the permanent employees. The plight of the contract workers was that they felt squeezed between the contractors on one side and the permanent workers on the other (Field notes from Telangana. 2017).

The work relations had a serious effect on the social relations and trust between workers. One observed that the social interactions between contract and

permanent workers were minimal. Often it was ridden with conflict leading to an erosion of trust among workers. Contract workers opined that they worked much harder than the permanent workers. The latter exercised their power over the former by giving them additional work. This was observed in hospitals and even in institutions delivering primary level care (Field notes from Telangana, 2017).

Motivation of workers has a bearing on their commitment to their specific role and the organization. So, one could argue that organizational commitment is premised on individual motivation and attitudes. In the context of multiple systems of contracts coexisting within an organization the idea of commitment gets questioned. The various determinants of commitment that includes loyalty to the organisation, the willingness to exert oneself for the organization and required levels of cooperation among workers gets fragmented in the forms of work arrangements that are seen presently. When cooperation and trust between workers weakens it affects the behaviour of institutions and has a bearing on the quality of patient care.

Thus, at all levels of work, there is a mix of personnel who have secure employment and those who are hired on a contract basis. The terms and conditions of these are different and so are the wages they receive. This often results in role conflict and weakens the bonds of trust within and across levels of

the work hierarchy. This undermines a team approach that is essential for the effective functioning of a hospital. Casualisation of the health work force therefore gives rise to multiple centres of authority and power. The contracting agent wields power over the hiring and retention of workers hence the commitment and loyalty to the institution is potentially undermined. At a deeper level the type of contract will also determine the motivation and attitude of workers. The insecurity and alienation of contract work affects the behaviour of workers and interpersonal relationships with their fellow workers, superiors and patients. This leads to erosion of trust among workers among one another and gets reflected in how the institution behaves with patients. Since there is no one administrative authority for managing these it results in the fragmentation of role, authority and power within a hospital.

Conclusion

The objective of this paper was to highlight the casualisation of the health work force in health services, which was an important aspect of the health sector reforms in India. Much of the scholarly work has not paid adequate attention to the nature of casualisation in public hospitals and other institutions at the primary and secondary levels of care. It further argues that health workforce studies have to go beyond a supply-demand framework of analysis. While this framework is important for planning for the health workforce deployment and

distribution it does not address the behavioural aspects of health services. Drawing upon Hasenfeld's conceptualization of health service institutions as human service organisations it is possible to analyse them as behavioural entities. It allows us to study health institutions as a complex network of hierarchical relationships between different levels of health workers with different skills and roles. It is the interaction between workers that builds a team approach to patient care. Thus, health institutions are a web of human interactions- between health workers and people who seek care. Viewed from this perspective, the paper argues that the changes brought through the reforms has casualised the terms of work and work relations within a public hospital. This goes beyond merely describing casualisation of workers in public hospitals to analysing the consequences of it for the culture of the institution.

The paper analyses the dialectic relationship between structural changes on individual worker motivation, attitude and behaviour. Casualisation was a structural change that was imposed as a health sector reform initiative for public institutions to improve economic efficiency. This had far reaching effects on restructuring work and social relations among health workers leading to role contradictions and conflicts. This resulted in a lack of solidarity among workers and led to the erosion of trust and loyalty to the public hospital. This fundamentally transforms the behaviour of the public hospital as representing

normative values of shared concern for patients. In our view casualisation of health workers undermines management practices that promote trust in public hospitals. It has been observed that: “high trust management practices are participatory, demonstrate procedural fairness, and encourage employees to share the goals of the organization and co-operate to achieving them” (cited in Gilson 2003, p.1460). The evidence and analysis of casualisation clearly points to be the antithesis of all the practices essential to maintain the values and ethics of a public hospital.

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