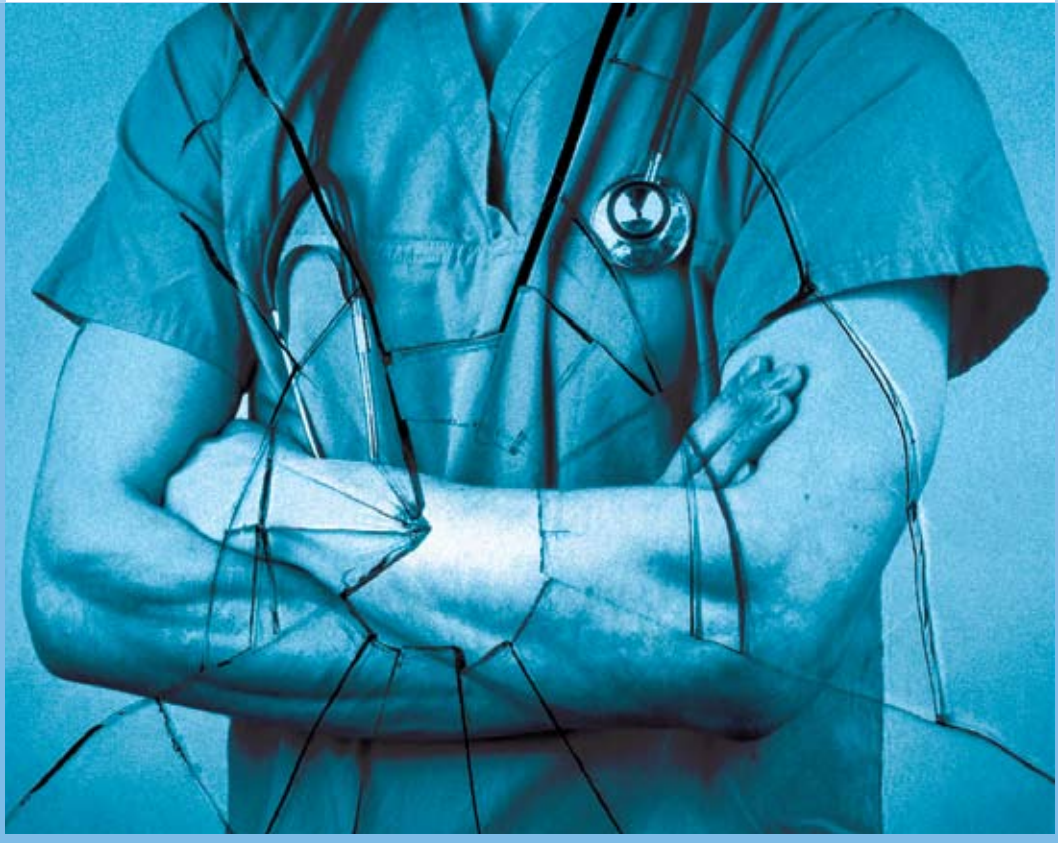
Non-Standard Work in the Healthcare Sector in South Asia

NON-STANDARD WORK & QUALITY OF HEALTHCARE SERVICES

CU Thresia



Public Services International, South Asia

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Author: CU Thresia

CU Thresia is a public health scholar working in the arenas of health inequalities and health policy, gender and women's health, social determinants of health, and non-communicable disease's risk factors prevention. Currently she is affiliated to Centre of Social Medicine and Community Health, Jawaharlal Nehru University, Delhi working on history of public health. She can be contacted at thresiaster@gmail.com

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Public Services International, South Asia
61, I block, sector 10, Faridabad - 121006, Haryana, India
Phone: +91 (0) 129 2261175,
mail: kannan.raman@world-psi.org and susana.barria@world-psi.org

Public Services International
45 Avenue Voltaire, BP 9, 01211 Ferney-Voltaire Cedex, France
Phone: +33 (0) 450 40 64 64, mail: psi@world-psi.org, website: www.world-psi.org

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NON-STANDARD WORK IN THE HEALTHCARE SECTOR IN SOUTH ASIA

The current set of publications under this series include the following:

Informalisation of Work: A Regional Overview covering the trends in informalisation of employment in the public healthcare sector in India, Nepal and Sri Lanka.

Informalisation and Trade Union Movement: A Case Study of Delhi exploring the evolution of the trade union movement in the sector against the backdrop of the continuous neglect of the public health sector.

Non-Standard Work and Quality of Healthcare Services providing a framework to understand the multiple paths through which growing informalisation of employment leads to the deterioration of the quality of services in the public healthcare sector, giving a stern warning against leaving this practice unchecked.

Informalisation of Work and Quality of Healthcare Services: A pilot study in Delhi, which delves into the experience of informalised workers in key public facilities in Delhi to give a compelling insight into the negative impacts of this practice for workers, and open avenues to think and understand how this in turn affects the institutions they work in and the health system more broadly.

Investing in Health: The Emergence of Healthcare Corporates in South Asia which provides a mapping of the nature of the private sector in Bangladesh, India, Nepal and Sri Lanka and its sources of financing.

Employment in Healthcare MNCs: A Case Study of Apollo Hospital, Dhaka which gives a compelling narrative of the exploitative working conditions in the sector, even amongst the most profitable companies in the sector.

Preface

Non-standard Work and Quality of Healthcare Services in South Asia shows that informalisation of employment in the healthcare sector in the region is taking place in the background of highly informalised economies. In Nepal and India more than 90% of staff are employed in informal work. While there was a belief that the public sector was being spared of this trend, this is not the case anymore, and definitely not in the healthcare sector. Workers often accept substandard employment terms and conditions of work under the expectation that in the near future this will give them access to a 'government job', i.e. employment secured in time, with a real wage that stands the downward pressures of inflation and dignified conditions of work. In fact, the desire for a government job is further strengthened and fed by the troubling reality of an economy dominated by informality, characterised by poverty wages and wage theft, employment insecurity and abusive and undignified working conditions. This desire has contributed to feeding the flow of informalised workers into the public sector, often taken advantage of by recruiters that make false promises that a fixed term contract or a contract through a third party will lead to a government job.

The booklet Informalisation of Work: A Regional Overview in this series shows the variances in the penetration of informalisation among countries in the region and between levels of administration. This booklet takes us into a framework to understand impacts on workers, on organisations and systems and on the patients from a perspective of the quality of services that are provided. It provides an understanding of the multiple paths through which growing informalisation of employment leads to the deterioration of the quality of services in the public healthcare sector, giving a stern warning against leaving this practice unchecked.

Yet, the elephant in the room is the freeze on hiring of health personnel and lack of new public healthcare facilities, linked to the cuts and stagnation of health budgets, despite a growing population. The numbers on the shortfall of skilled health workers are daunting: 35,00,000 in India, 5,80,000 in Bangladesh, 5,00,000 in Pakistan, 50,000 and 35,000 in Nepal and Sri Lanka respectively. This is not any more linked to a lack of training capacity, but increasingly reveals the inability

of the public healthcare sector to absorb the required workforce, especially nurses and midwifes.

Global trade union federations, including PSI have been advocating for Quality Public Services with Decent Work. In January 2011, the Council of Global Unions that brings together all the international trade union federations launched a campaign for Quality Public Services. The Charter that delineates the contours of this Campaign states: "Quality public services available to all enhance the quality of people's lives and are fundamental to the creation of societies that are equal, prosperous and democratic." It further asserts: "the highest quality services can only be delivered by workers whose rights are fully respected." The documents link the campaign for quality public services, with that for adequate public resources and calls for a commitment from Governments to invest in the future of people and their communities. As we know too well, the introduction of user fees is a prescription for inequity. Public-private partnerships serve private interests rather than the public good and have shown their inadequacy in providing essential services. The literature confirms that they are less efficient and less effective in delivering quality healthcare services.

Fair taxation is a core function of democracy, yet, in many countries, the richest 1% pay proportionately less tax than everyone else. Profitable Transnational Corporations (TNCs) use loopholes and tax havens to avoid paying their share. They also establish monopoly distortions, reaping super profits. Philanthropy is no substitute for fair and reasonable taxation. A taxation system based on fairness and ability to pay is the first step to finance quality public services in all communities. PSI is a member of the Global Alliance for Tax Justice and is committed to work along with its allies to ensure a fair tax system that allows governments to meet their obligations to deliver social and economic rights to all.

Susana Barria
Public Services International

CHAPTER 1

INTRODUCTION

A healthcare workforce plays a crucial role in the functioning of any national health system. The World Health Organisation (WHO) identifies a healthcare workforce as one of the six key building blocks of a health system. A well-trained and organised healthcare workforce is essential and a prerequisite for providing quality healthcare services and improving the efficiency and responsiveness of the healthcare system. WHO defines a health workforce as 'all people engaged in actions whose primary intent is to enhance health' and a health system comprising of 'all organisations, people and actions whose primary intent is to promote, restore and maintain health.'The development and equitable distribution of a healthcare workforce across geographic regions, gender, class, caste and ethnic diversities has a critical impact on health indicators such as infant mortality and maternal mortality which reflect any nation's health status. The numerical strength of the workforce, its skill mix, commitment, efficiency and equitable geographical distribution matter in the provision of quality healthcare services and their better utilisation across social boundaries. This calls for standard forms of employment and skill development of health personnel.

However, in a global context where markets are being created and promoted for the provision of essential services on the pretext of increasing competition and cost-effectiveness, sometimes through the prescriptions of the World Bank or as a precondition of the International Monetary Fund's (IMF's)structural adjustment programme (the World Bank, 1993), non-standard forms of labour in healthcare are increasing. Growing evidence from across the globe indicates that intrusion of market logic into the healthcare sector has important and mutually reinforcing adverse implications for healthcare delivery, its systems, workforce, the quality of services and health outcomes of populations (Banerji, 2006; Baru, 2004; Navarro, 2007; Qadeer, 2009).

From a worker's rights' perspective, informalisation of the labour force reduces the participation and autonomy of workers (Benach et al., 2010) whereas from a

systems' perspective, it trivialises and fragments the healthcare system including workforce development. All these have serious implications for the quality of healthcare services.

During the past few decades of globalisation and privatisation, socio-political and cultural transformations with unstable forms of employment have been less favourable for a normative development of the health workforce. Needless to say, despite momentous improvements in social, economic and technological arenas in the last century and a couple of decades of the 21st century, South Asia woefully lags behind in achieving the desirable goals of health development, particularly with regard to the healthcare workforce (UNDP, 2014; UN, 2013; WHO, 2015a).

In terms of the quality of services, the neoclassical economic assumptions emphasise thatstate patronage of healthcare employment exhausts much of the resources (nearly 70 per cent of the health budget)on pay and allowances, hampering economic efficiency, while opening up the economy to competitive market forces will increase the efficiency of the economy and effectiveness of services. Several studies have supported such arguments making deregulations and the retreat of the state from employment inevitable in the public healthcare sector. In the early 1990s, the World Bank in its *World Development Report: Investing in Health* (1993) categorically emphasised the misallocation of public spending on low cost-effective interventions, inequalities in resource allocations, wastage, inefficiencies and poor motivation of healthcare workers, particularly in a low-middle income setting. Its panacea for these issues largely hovered around the full opening up of the health sector for private finances and services. After 20 years, the Lancet Commission on Investing in Health (Jamison et al., 2013) echoed and reinforced the same frame for global health for 'converging with generations,' while the World Health Report (2013) accepts the essentials of this framework which largely compromises the idea of comprehensive primary healthcare by pushing a selective and techno centric approach putting global organisations for health financing at the centre stage (Qadeer and Baru, 2016).

However, a growing body of evidence indicates that structural adjustment policies initiated since the late 1970s in South Asia and the subsequent privatisation considerably weakened the building up of a health workforce and the quality of services in the region (Baru, 2004; Thresia, 2013). The increasing commercialisation of the healthcare sector across the globe has led to a corresponding

expansion of informal/ non-standard work in health systems in both the developing and developed nations, but this has not been uniform (Sexton, 2003). In this restructuring, South Asian countries were home to the world's highest proportion of informal workers (86-95 per cent in 2013), higher than the sub-Saharan African region (MHHDC, 2015).

In South Asia the public sector was considered a model for standard forms of employment with better conditions of work, employment and employment security.[1] In India too the public sector made efforts to take over enterprises and employees when the private sector failed to protect the workers and so continue the operations of an enterprise. However, with the advent of structural adjustment programmes and the retreat of the state since the 1980s, informalisation is now creeping into the public sector including in the health sector.There has been a scarcity of reliable statistics on the proportion of informalisation of the healthcare workforce in South Asia. Notably, between 2004-2005 and 2011-2012, there was an increase in informal employment in the organised sector in India of 15.2 million workers although informal unorganised sector employment declined by 5.8 million to 309.9 million (Government of India, 2015). Such evidence is growing in all countries in South Asia (ILO, 2014; Otobe, 2013). The major reasons for an increase in non-standard employment in the organised sector have often been attributed to the poor performance of the workforce, rather than the regional, national and international policy shifts and associated deregulations.Contracting services were promoted to improve the labour and healthcare economy.

Discourses on 'new public management' since the late 1980s for making public organisations more accountable, flexible and 'business like' (Condery and Ledwinka, 2008) have driven public sector institutions including healthcare to adopt such a paradigmatic shift. This hasencouragedcontractualisation of employment of several categories of health personnel including the creation of a new category of 'public health managers' in the healthcare delivery system.

Experiences from the world over including from the Australian healthcare industry have been highlighted to showcase success stories of public health management (Beattie and Osbourn, 2008 cited in Condery and Ledwinka, 2008). However,

1 The International Labour Organisation (ILO, 2015) defines non-standard forms of employment as 'work that falls outside the scope of a standard employment relationship, which itself is understood as being work that is full-time, indefinite employment in a subordinate employment relationship.' See http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/meetingdocument/wcms_336934.pdf .

several studies from the developed and developing world have critiqued it from different perspectives.

Historically in South Asiathere have been severe shortages of a health workforce, inequalities in distribution of health workers, gender discrimination and an unbalanced skill mix in the prevailing health workforce and poor quality service provisions (WHO, 2012, 2013). Despite a shortage of the workforce, the public sector was unable to take in qualified populations in the labour force.In order to address labour shortages and quality issues, rather than employing permanent labour, contractualisation of health professionals and ancillary personnel has become a norm in the region, except in Sri Lanka.[2] Although some studies have focused on aspects of the human resource shortage in the region (Bermen et al., 2009; Rao et al., 2012) there is a scarcity of comprehensive studies analysing the complexities of the structural transformation of employment in healthcare and the resultant informalisation of the health workforce and its linkages to the quality of services.

Vast majorities of contract or casual workers toil under undignified and hostile terms where they can be paid less than half of what the permanent workers get and their services terminated at any time, which leaves an indentation in the quality of care.

OBJECTIVES

Given the radical shift in public sector healthcare employment in the South Asian region, the major objective of this study is to understand the dynamics of labour transformations focusing on non-standard forms of employment and its implications both on the quality of work conditions and the quality of healthcare services. In order to unravel the complexities and to a get a comprehensive and nuanced understanding, the specific objectives are to:

a) explore the linkages between informalisation of employment and the quality of healthcare services in the hospital sector, looking at different categories of workers such as nurses, nursing orderlies, technicians, ward attendants and housekeepers, map the paths by which the dynamics of employment affect the services provided by different workers, and examine the need for formal standard /permanent workforce in hospital settings in order to provide quality healthcare.

2 For an overview of trends in informalisation of employment in India, Nepal and Sri Lanka, see "Informalisation of Work: A Regional Overview" in this series.

For this, we need to ask several research questions including an examination of thevarious types of contractual appointments and the different agencies associated with them;the terms and conditions of work of contractualised workers and the role of contractors in workforce recruitment; perceptions and experiences of workersincluding on their work conditions andinterpersonal relations among andbetween differentcategories of employees; and how does informalisation/ contractualisationand splitting functions under multiple authorities affect the workers and the healthcare system.

METHODS

Given the thematic intricacies, we need an interdisciplinary methodological frame for crossing disciplinary boundaries. Thus, in order to get the linkages of informalisation of work and quality of services, we primarily adopted secondary sources of published and unpublished literature including research publications and reports by several local, national and international agencies and organisations. Further, to get a deeper understanding of the issues includingthe perceptions of the informal workforce, we conducted 15 key informant interviews/case studies among the different categories of contractual workers –nurses, nursing orderlies, laboratory technicians and housekeepers – in public sector hospitals in Delhi and Kerala. Interviews with a few workers in one of the autonomous healthcare institutes under the Government of the National Capital Territory (GNCT) Delhi were also conducted to get an idea of the perceptions of the workers in such government institutes where most workers are contractual. We also held interviews with state level public health administrators, the medical superintendent of a hospital and leaders of workers unions who are working as paramedics in public hospitals.

CHAPTER 2

UNDERSTANDING NON-STANDARD WORK AND QUALITY OF HEALTHCARE
A CONCEPTUAL FRAME

The last few decades have witnessed increasing debates on strengthening the health workforce and providing universal access to healthcare. The structural adjustment programmes since the 1980s have introduced several reforms in the health sector including informal labour deployment allegedly to respond to inaccessibility and inefficiency issues. The contractual/informal workforce in healthcare includes all health personnel working in the health sector whoare insufficiently covered or protected in terms of health, safety and welfare measures.1Informal/non-standard/ contractual work, as evident in the term itself, is far from formal conditions ofjob security and health and safety. ILO defines informal work as 'all economic activities by workers and economic units that are-in law or in practice –not covered or insufficiently covered by formal arrangements.'Given the increase in non-standard forms of labour, ILO places employment at the core of socioeconomic policies emphasising the fundamental rights of workers, promoting productive employment for women and men, upholding social protection for all and endorsing social dialogue at the workplace (ILO, 2013).

Thus arguments favouring labour market restructuring include:

- Increased provider competition will augment technical and allocative efficiency within the system.
- Contractual relations will enhance efficiency of the purchaser and provider.
- The contracting process may increase transparency and decentralisation of managing responsibility (Broomberg, 1994).

However, evidence from the developed (including the National Health Services of the United Kingdom) and less developed world on such restructuring labour

1 Informalisation and contractualisation are used interchangeably.

in healthcare indicates a less transparent experience (Palmer, 2000). Data indicates that worldwide since the 1980s, associated with the globalisation of the labour market and deregulation initiatives, standard employment opportunities with legal protection, employment security, work schedule organisation, adequate remuneration, workers' rights, workers' participation and autonomy have eroded (Benach et al., 2010). Besides this, several studies have argued that neoliberal policies and programmes have adversely affected health and healthcare of much of the populations in the developed and developing world (Krieger, 2009; Thresia, 2013).

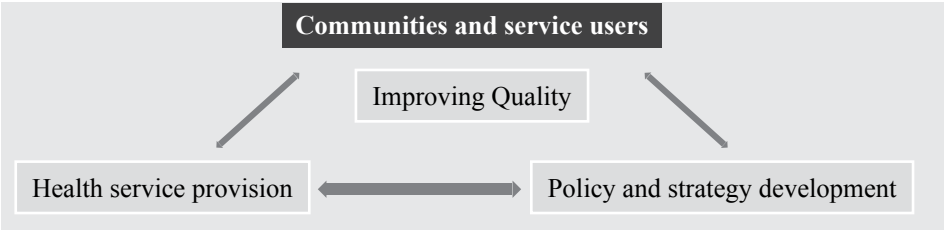
This is because of these sectors' potential for human development which is linked to the tangible and intangible arenas of life, as well as employment and healthcare sectors' contribution to population health outcomes while the quality of care itself has multiple layers and levels including tangible and intangible aspects.

Thus, the conceptualisation of informal work and its implications for quality of healthcare begins with the premise that both employment and healthcare services cannot be considered as derivatives of economic growth.

DEFINING THE QUALITY OF HEALTHCARE

Wider theoretical and practical discussions on improving the quality of medical care services gained momentum during the 1980s and 1990s, although the exploration of the concept of quality of medical care had started in the 1960s. Much of this had come from the industry and commerce settings where quality assurance was a part of performance management which originated in management studies (Martinez, 2001). The neoliberal period with increasing privatisation witnessed an increase in such debates in healthcare because of widening inequalities in health and erosions in access to healthcare. According to WHO (2006), the increased focus on the quality of care is due to increasing concerns over clear evidence that expected outcomes were not achieved and there were wide variations between and within healthcare delivery systems both in the developed and developing worlds.Further, health systems, particularly in the developing economies need to optimise resources and expand population coverage and scale up their quality based on local strategies to maximise results (ibid). However, recent studies indicate that the debates on quality in healthcare were by and large limited to curative medical care and the assumptions that portrayed the private sector as a better quality service provider in terms of infrastructure, technology, less bureaucratic hurdles and more responsiveness to

Figure 2.1: Roles and responsibilities in improving the quality of healthcare Source: WHO (2006).



patients' needs as compared to the public sector which strengthened the privatisation of healthcare (Baru, 2008).

The complexity of health and healthcare often make it difficult to come up with easy definitions and measurements of quality. Yet, several definitions, perspectives and approaches have evolved in a study of the quality of healthcare. These studies range from a 'patient's perspective to that of the providers and managers,' while different approaches for measuring quality range from focusing on biomedical parameters, infrastructure, technology and bureaucratic involvement to population experiences (Baru, 2008; Das and Hammer, 2010; Donabedian, 2005; WHO, 2006). Moving beyond a limited approach based either on structural issues or on biomedical parameters, Donabedian (2005) provides a comprehensive frame for assessing quality based on several dimensions of interactive relations, infrastructure and outcomes. His definition of the quality of healthcare focuses on many structural aspects, along with the processes of medical care and the outcomes.A working definition by WHO suggests that the health system should make improvements in six areas of quality – effectiveness, efficiency, availability, acceptability/ patient-centred, equity and safety. The responsibilities are at multiple levels – policymaking, health services and community (Figure 2.1).

In an expanded conceptualisation of the quality of care in public health, Baru (2008) argues that we need to focus on several intangible qualities – functional, technical, interactive, corporate and social accessibility – along with tangible dimensions – infrastructure, location, availability, affordability, physical accessibility – of quality:

- functional quality includes service delivery aspects including the time taken, and administrative procedures.

- technical quality includes effectiveness and comprehensiveness of the care.
- interactive quality involves different aspects of patient provider interactions such asresponsiveness and reliability.
- corporate quality is concerned with organisational aspects.
- accessibility is concerned with access of varying caste, class, gender and ethnic populations.

INFORMALISATION AND QUALITY OF SERVICES

The process of building a workforce is multi-dimensional. It involves 'interdependency between an individual and the organisational culture, policies and structures, and enabling strategic capacity for linkages between a myriad of issues such as information, ethics, awareness, motivation and behaviour'(Biscoe, 2009).

Given the various dimensions of quality and the multiple levels of responsibilities, formal structures of employment in healthcare are important. Notably, healthcare work is much beyond a job or employment as the job framework does not reckon with the important human development implications of workas in the case ofcaring and voluntary work (UNDP, 2015). When market logic – contractualisation – is applied to healthcare, considering health as a 'commodity' that drives the economy, the interdependencies enabling capacity building will be severely constrained and its implications will be at multiple levels (Figure 2.2):

- **At the workers' level**, contractualisation may lead to adverse impacts in work tasks (intrinsic quality of work and autonomy of workers), working conditions, employment conditions and employment relations (Benach et al., 2010). Poor working conditions, psychosocial pressures, less autonomy, lack of safetyand 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 hasimportant fall-outs. It decimates the quality of life of the workers with poverty, ill health and miseries and it also affects the system.
- **At the organisational and health systems' levels** a dehumanising/decapacitating environmentleads to several pathologies. Firstly, given that the chances for ruptures and discontinuities in services are high, either due to termination

Figure 2.2: Linkages between contractualisation of health and low quality services

or resignation, the transparency and accountability of the system can be questionable. It may also create moral and ethical dilemmas in the system arising out of a violation of rights. It has been argued that since the advent of new public management in the 1990s and the many instances of contracting of services the world over public organisations have sought to make their organisations more accountable and flexible (Condrey and Ledwinka, 2008). On the contrary, studies from both developed and developed nations indicate that employment relations such as contractualisation were unclear and clouded (Benach, 2010; Palmer, 2000; Srivastava, 2016). Such 'flexibility and accountability' also has to be examined in the context of organisational involvement and commitment of the workers. Secondly, it leads to a highly alienated and less committed workforce. The fragile nature of the work and the ruptures in continuum, as Etzioni (1975) argues, lead to an intense negative organisational involvement. In his study on health systems in Kerala,Jagadeesan (2013) argues that contractual/temporary employment in healthcare does not imbibe a vision in long-term system building. The less skilled and poorly committed workforce deepens the organisational and systemic erosion of the quality of services. Thirdly, 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 thatwas proposed during the late 1970s in the Alma Atta declaration.

- **At the patients' level**, the processes of informalisation and resultant pathologies in the system reflect in the services provided. The quality of services in terms of availability, efficiency, accessibility, cost-effectiveness,

responsiveness and patient-provider relationships are severely compromised. This weakens patients' trust in the system and violates their fundamental rights to health and access to skilled and quality healthcare services.

Figure 2.2 gives the linkages between the contractualisation of the workforce and low quality services. This conceptual frame leads us to focus on various dimensions of non-standard healthcare work and its effect on the quality of carein South Asia.

CHAPTER 3

NON-STANDARD WORK IN SOUTH ASIA

The increase in non-standard work in the employment sector in South Asia is a major characteristic of the restructuring of economies that began in the late 1970s and picked up pace during the 1980s and 1990s. Sri Lanka embarked upon structural adjustment programmes during the late 1970s, Pakistan in the early 1980s, Nepal and Bangladesh during the mid-1980s andIndia initiated major reforms only in 1991, although by the mid-1980s some domestic reforms particularly in the industrial sector were introduced. Until the 1970s, high tariffs, regulations and high public sector investments were some of the policies followed in South Asian economies. Over the past few decades of economic reforms and structural adjustment programmes, 'jobless growth,' particularly in the formal sector is apparent in many South Asian countries (Ghosh, 2011). However, between 1991 and 2010 there was a decline in unemployment rates in South Asia (decreased from 4.5 per cent to 3.5 per cent) (MHHDC, 2015). This was accounted for by underemployment and low quality employment. Between 1980 and 2010, despite increased annual GDP growth rates in South Asia (5.9 per cent), employment creation was largely limited to informal work. In 2010, 475.9 million people in the region worked in vulnerable jobs with limited employment security and social protection, accounting for one in every three such workers in the world.

In South Asia, much of the workforce, over 80 per cent, is engaged in the informal economy, as well as the informal labour force in the formal economy (ILO, 2014). South Asia ranks at the top (82 per cent) in informal employment in non-agricultural work followed by sub-Saharan Africa (66 per cent) (UNDP, 2015). That is, in non- agricultural work, eight out of every 10 workers in the region are employed in the informal sector.Between 1983 and 2010, there was an increase in casual labour in India; and except in Bangladesh and Sri Lanka, during the 2000s the proportion of unpaid family labour (Pakistan: 28.3 to 29.1 per cent,

Nepal: 43.3 to 45.7 per cent) shows an increase (MHHDC, 2015). In India during the early decades of the neoliberal period (1994-1995/2004-2005) employment grew by only 1.8 per cent per annum as compared to 2.02 per cent in the preceding decade. Between 2004-2005/2009-2010 there was a decline in employment with this going as low as 0.22 per cent per annum (Papola and Sahu, 2012). Nevertheless, during the entire post-reform period the service sector's performance has been relatively better (an average of 3 per cent per annum) though not commensurate with a GDP growth of 10 per cent per annum.

In India, employment in the entire organised sector (any public or private enterprise employing more than 15 workers) in 2009-2010 was only 16 per cent with a nominal increase from 14 per cent in 1999-2000 (Table 3.1). During the same decade, in all other countries in South Asia, there was a marked decline in the proportion of employment in the organised sector. Notably, Sri Lanka's formal workforce nearly doubled as compared to that of India.

In India, between 2004-2005 and 2011-2012 an increase in informal employees on a regular basis was at 4.5 per cent per year, compared to an increase of 2.1 per cent per year for formal employees (Srivastava, 2016). Informal workers on a regular basis increased at a rate of 4.6 per cent per year in the entire non-agricultural sector, as against an increase of 1.9 per cent per year for formal employees. Notably, informal employment grew by 5.8 per cent per year among all employees outside agriculture as against a 1.3 per cent growth in formal employment.

In the process of informalisation, caste and gender segmentation of the labour market further discriminatesagainst women and the lower castes. In 2010, in South Asia as a whole women's work participation rate was much lower (32 per cent) while many of the employed women were in the informal sector. Between 1990 and 2013, women's labour force participation rate in the region decreased from 35 per cent to 30 per cent. Between 2004-2005 and 2009-2010 there was an acceleration of informalisation among women labour in India as it increased from 32.6 per cent to 39.9 per cent in rural areas and from 16.7 per cent to 19.6 per cent in urban areas. The corresponding figures for the same period for men were 32.9 per cent to 38 per cent (rural) and 14.6 per cent to 17 per cent (urban) (Planning Commission, 2011). Women are estimated to contribute to 58 per cent of global work and men 42 per cent, yet, they earn 24 per cent less than men; and notably, globally, 32 per cent of the businesses have no women in senior managerial positions while they occupy only 25 per cent of

Table 3.1: Trends in employment patterns in major South Asian countries

COUNTRY/YEAR	PERCENTAGE OF EMPLOYED PERSONS	
	Organised sector	Unorganised sector
India		
1999-2000	14	86
2009-2010	16	84
Pakistan		
1998	32.2	67.8
2010	26.7	73.3
Bangladesh		
1996	17.9	82.1
2010	12.5	87.5
Nepal		
1999	6.4	93.6
2008	3.8	96.2
Sri Lanka		
2006	38.4	61.6
2010	37.4	62.6

Source: MHHDC (2015).

the positions in administrative and managerial arenas in the business world (UNDP, 2015).

South Asia is no different; in fact it might be worse in women's work contributions and low earnings compared to men. In terms of employment patterns of Dalits, the NSS 68th Round (2011-2012) data in India indicates a low employment rate among Dalits as compared to others. Not surprisingly, they were overwhelmingly represented in casual labour than in salaried jobs or self-employment. Employment conditions of Dalits in other South Asian countries, particularly in Bangladesh, Pakistan and Nepal are even worse (Chowdhry, 2009; IDSN, 2015; ILO, 2005; Jamal, 2009; Otobe, 2013).

Similarly, rural-urban disparities in casual labour were apparent in the statistics asin 1983 rural India had 26.4 per cent casual labour as compared to 2.9 per cent in urban areas while by 2010 this had increased to 28.3 and 4.7 per cent respectively (MHHDC, 2015). In a shift in employment patterns since the 1990s a higher proportion of self-employed workers in India, Nepal, Sri Lanka, Bangladesh

and Pakistan belonged to populations above the poverty line while a high proportion of casual labourers in these countries were from below poverty line households, and often from the lower castes, particularly Dalits.

Thus, historically despite substantial developments and socioeconomic and political transformations in the post-colonial era, South Asia did not perform well in the creation of decent employment and its equitable distribution in the neoliberal period. During the neoliberal period, the employment situation became worse with declining formal employment in the organised sector and an increase in non-standard forms of jobs with insecurities and precarious conditions (Nguyen et al., 2016). Besides the informalisation of employment, much of the population in South Asia is facing challenges of poverty, illiteracy, malnutrition, gender inequalities, ethnic discrimination, poor health outcomes and lack of access to quality healthcare services (Thresia, forthcoming; UNDP, 2014). It is in this context that the informalisation of employment in the public healthcare sector is examined and analysed.

CHAPTER 4

THE HEALTHCARE WORKFORCE IN SOUTH ASIA

The healthcare workforce in South Asia is not uniform in structure and nature. The characteristics of medical/health systems and categories of the workforce are diverse and pluralistic in nature, type and ownership. The coexistence of plural systems of medicine in South Asia ranges from traditional healthcare systems– ayurveda, unani, yoga and siddha – to homeopathy and allopathic medical care. The workforce comprises of various medical, paramedical and non-clinical personnel with varying roles and functions. They range from doctors, dentists, nurses and midwives to pharmacists, technicians, medical assistants, housekeepers, laundry workers, catering staff, security personnel, ambulance drivers, mortuary workersto non-physician clinicians and community health workers. The numerical strength of different segments of the health workforce in South Asian countries is given in the Table 4.1. According to the National Occupation Classification of India, allopathic healthcare providers include doctors, dentists, nurses, midwives, pharmacists, technicians, nutritionists, sanitarians and other administrative employees.WHO defines a health workforce as 'all people engaged in actions whose primary intent is to enhance health.'

A satisfactory coverage of primary, secondary and tertiary care mainly depends on the availability of adequately skilled health professionals across and within all health facilities and geographical areas. Nevertheless, there has been a significant shortage of the health workforce in South Asia.

DEFICITS AND DISPARITIES IN THE HEALTHCARE WORKFORCE

There are no best standards or any consensus to project the sufficiency of a health workforce. Many factors such as a population's health needs, forms and types of healthcare services and health workers' efficiency and productivityinfluence health workforce requirements and adequacy (WHO and GAHW, 2013). The WHO (2006) standard (23 skilled health workers –midwives, nurses and

doctors) for health workforce requirements based on a single service, 80 per cent coverage of assisted deliveries.Based on the skilled workforce requirement for 80 per cent coverage of trained medical personnel assisted deliveries, WHO estimated a standard of 23 skilled health workers – midwives, nurses and doctors – per 10,000 population. ILO estimates that at least 41.1 health workers (physicians, nursing and midwifery personnel) per 10,000 population are necessary to provide services to all in need. This figure is based on calculations of median values of the density of health workers in countries where socioeconomic conditions and health financing characteristics are conducive for universal coverage.[1] In 2015, on the basis of an analysis conducted according to the sustainable development index (reflecting on a broader range of services and globalburden of diseases) methodology WHO identified an indicative threshold of an aggregate density of 44.5 doctors, nurses and midwives per 10,000 population (WHO, 2015a). This value is not a target to achieve for the countries or at the global level but it is used for needs-based estimates in this document (WHO, 2015a).

Globally, South Asia has among the worst population health professional ratios, second only to sub-Saharan Africa. The deficit in the health workforce in South Asia has been reflected in terms of the numerical strength of healthworkers – doctors, nurses, midwives, dentists and technicians –and their qualifications and distribution across geographical and social boundaries (Baru, 2005;Rao et al., 2011, 2012; WHO, 2012a,2013). In all South Asian countries including Sri Lanka, the most developed country in the region in terms of health and equity, there has been a staggering shortage of health personnel at different levels. However, Bangladesh has managed to increase its physician population ratio considerably during the past three decades.

Among health personnel, nurses and midwives constitute more than 50 per cent of the health workforce in many countries. It is estimated that of the 43.5 million health workers, a little less than half (20.7 million) are nurses and midwives. There is a shortage of these much needed workers, along with physicians and technicians. In South Asia there has been a greater shortage in the health workforce and currently as a proportion to the population, Bangladesh has the highest deficit followed by Nepal while Sri Lanka has the lowest shortfall (Table 4.1). India has a relatively better density of different health professionalsas compared-to other South Asian countries (Table 4.2). Nevertheless, during 2007-2013, none

1 For more information see http://www.ilo.org/global/about-the-ilo/multimedia/maps-and-charts/WCMS_244649/lang–en/index.htm and http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_249229/lang–en/index.htm.

Table 4.1: Health workforce deficit in South Asian countries

	Current workforce (per 10,000 population)	Shortfall (41.1/10,000)	Total workforce shortfall
Bangladesh	5.74	-35.36	5,80,000
India	16.45	-24.65	35, 00, 000
Nepal	6.7	-34.4	50, 000
Pakistan	13.7	-27.4	5, 00, 00
Sri Lanka	24.22	-16.88	35, 000

Source: Barria (2016).

Table 4.2: Paramedical and ancillary health workforce distribution in major South Asian countries

COUNTRY	NUMBER OF HEALTH PERSONNEL						
	Nurses & midwives	Nurses	Medical assistants	Pharm-acists	Lab health workers	Lab tech-nicians	Radiog-raphers
Bangladesh	32,839 (2011)	26,899 (2011)	7,365 (2011)	9,411 (2007)	1,985 (2007)	-	-
India	21,24,667 (2011)	21,24,667 (2011)	65,500 (1991)	630,766 (2012)	15,885 (1991)		15,886 (1991)
Nepal	11,825 (2004)	5,664 (2004)	-	1,200 92012)	3,209 (2004)	3,104 (2004)	105 (2004)
Pakistan	100,397 (2010)	73,244 (2010)	18,862 (2004)	8,102 (2004)	9,744 (2004)	6,323 92004)	1,670 (2004)
Sri Lanka	35,367 (2010)	35,367 (2010)	1,107 (2010)	753 (2012)	2,950 (2012)	1,407 (2012)	1,478 (2012)

Source: WHO Global Health Observatory data.

of the countries in South Asia had skilled doctors, nurses and midwives equivalent to theaverage distribution for lower middle income countries (physicians 7.9, nurses and midwives18.0 per 10,000) (Table 4.3).

'While there are no golden standards for assessing the sufficiency of the health workforce, WHO estimates that countries with fewer than 23 health-care professionals (counting only physicians, nurses and midwives) per 10,000 population will be unlikely to achieve adequate coverage rates for the key primary

health-care interventions prioritised by the Millennium Development Goals' (WHO, 2009).

According to WHO (2012a), most of the countries in South Asia –Bangladesh, Nepal, Pakistan andIndia – have a greater deficit (23 health workers per 10,000 population) which is considered the minimum workforce to achieve 80 per cent coverage of essential health interventions.

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In South Asia, skilled nurses per 10,000 people was only 14.1 and for doctors the figure was 6.7 in 2010 (WHO and GHWA, 2013). Given the myriad health issues, failures in the health system and severe shortages of qualified health personnel, Bangladesh's country cooperation strategy 2014-2017 (WHO, 2014) prioritises strategies for strengthening the health workforce. The ratio of nurses to physicians in Bangladesh was only 0.4 (Ahmed et al., 2011). Capacity building for evidence based nursing and midwifery services and enhancing the capabilities of healthcare providers were seen as some pertinent strategies to ensure quality of services. While Nepal has introduced several strategies including mandatory training and medical fellowships to strengthen the public sector's provisioning of healthcare (Ministry of Health and Population, 2014) its health sector programmesidentify a critical shortage of health personnel – doctors, specialists and particularly staff nurses. Only two-third of doctor and nurse vacancies are filled in Nepal (ibid). All major countries in South Asia, except Sri Lanka, have a similar milieu.India had a density of only 13.4 health workers – allopathic doctors, nurses and midwives – in 2005, a little over half of the minimum requirement (Rao et al., 2012).

South-Asian countries' (organised under WHO's East Asian region) lack of access to healthcare workers was the highest in the world. This was nearly double that of the upper middle-income countries' deficit (3.6 million) (Table 4.4).It is estimated that by 2030globally we will need 54.5 million healthcare workers indicating an 18 per cent increase over the need in 2013. In estimates of health workers' deficit (difference between SDG calculated need and supply, that is,the need for health-care workers minus the supply of healthcare workers),the SDG index of 44.5 health workers per 10,000 population was used to estimate the required number

Table 4.3: Health workforce (per 10,000 population) in major South Asian countries (2007-2013)

Country/Income group	Physicians	Nurses and midwives	Pharmacists
Bangladesh	3.6	2.2	0.6
India	7.0	17.1	5.0
Nepal	2*	Nurses-2* Midwives-6	1.4
Pakistan	8.3	5.7	—
Sri Lanka	6.8	16.4	0.4
Low income	2.5	5.5	0.4
Lower-middle income	7.9	18.0	4.2
Upper-middle income	16.1	26.3	3.4
High income	28.7	88.2	10.1

Note: * Nepal data is for 2012.
Source: WHO's World Health Statistics (2015).

Table 4.4: Estimates of health workers' deficit relative to current supply in WHO's South East Asian region, by income groups (2013)

Region/Income groups	Deficit (SDG composite method, 44.5 per 10,000 population)			
	Medical doctors	Nurses/ Midwives	All cadres	Total workers
South East Asia region	12,83,457	31,29,308	24,48,532	68,61,297
Low Income	848,770	21,03,387	17,57,220	47,09,378
Lower Middle Income	15,66,399	41,98,354	31,54,307	89,19,059
Upper Middle Income	142,927	25,59,092	900,143	36,02,162
High Income	4,715	340,919	52,118	397,752

Source: WHO (2015).

by 2030 to get an adequate coverage of the 12 SDG tracer indicators.Notably, the estimated increased need for low-income countries is as high as 40 per centas compared to an increased need of 6 per cent for high-income countries.

In Nepal, Bangladesh and Pakistan the skill mix that is available in government facilities –a high shortage of qualified doctors and nurses - raises questions about the quality of care (Ahmed et al., 2011; WHO, 2012). And Sri Lanka's requirement for qualified employees including nurses is well documented (Abeycoon, 2003).The Indianhealth workforce draws a disquieting picture with a considerable proportion of inadequately qualified workers. Rao et al.'s 2012) study based

Table 4.5: Density of qualified health workers (per 10,000) population in rural and urban India

Category of health workers	Qualified health workers 2011-2012	
	Rural	Urban
Allopathic Physicians	0.8	9.1
Nurses & Midwives	1.3	7.2
Ayush practitioners	0.2	1.4
Dentists	0.0	0.9

Source Rao et al., (2012, 2016).

on the Census and NSS data indicates that in 2005 India had 20 health workers per 10,000 population. Nevertheless, a qualified healthcare workforcewas only a little over 8 personnel per 10,000. NSS 68th Round (2011-2012) data shows a little improvement in health worker density (20.9 per 10,000), yet more than half (56.4 per cent) of them were unqualified including 42.3 per cent allopathic doctors and 58.4 per cent nurses and midwives. This pushed the qualified doctors, nurses and midwives to only 3.3 and 3.1 respectively for 10,000 population in the country (Rao et al., 2016).

GENDER AND RURAL-URBAN INEQUALITIES

Apart from deficits in the health workforce and its qualifications and skill mix, there are several professional/specialty, gender, geographic, institutional, services and public-private imbalances in the healthcare workforce.

In South Asia, multiple inequalities are reflected in unequal workforce distribution across rural-urban regions and terrains, inadequate specialists and services within and between facilities, gender disparities in the professional workforce and public-private differentials in health professional representation.

The deregulations associated with the onset of structural adjustments enhanced the unregulated growth of the private sector in South Asian healthcare and exacerbated inequalities and imbalances. In workforce distribution in India, rural-urban disparities make the rural areas (physician 3.28, nurses and midwives 4.13 for 10,000 population) more vulnerable where the allopathic physicians' and nurses' density was nearly four times lower than that in urban areas (physician 13.34, nurses and midwives 15.88 for 10,000 population). In terms of availability of qualified health workers, as compared to urban areas rural areas were further disadvantaged with an over 10 times low density of doctors and over five times low density for nurses and midwives (Table 4.5).In the case of specialists the

deficit in India was even more compelling as there was a shortage of 55 per cent obstetricians in rural India, according to rural health statistics.

The human opportunity index measuring availability of services and its equitable access across social groups is substantially low for all South Asian countries. For basic health services like institutional births access was limited to less than 30 per cent in all countries except for Sri Lanka (Rama et al., 2015).

Disparities in the distribution of specialists between the public and private sectors were appalling. Ranadive et al.'s (2012) study in rural Maharashtra shows that the representation of gynaecologists in the private sector was eight times higher as compared to the public sector. In their long-term study on healthcare seeking in India, Das and Hammer (2010), focus on the quality of care in terms of competence of public and private healthcare providers and their efforts to improve the situation of patients. Their study shows class differentiations in access to competent care where the rich people have more access than the poor to doctors in both the private and public sectors because more competent doctors from both the sectors are concentrated in rich neighbourhoods where they put in a lot of effort. Sri Lanka, despite having greater public sector inputs for the development of its health workforce reported a severe shortage of specialists and lack of trained staff for the provision of quality healthcare services in rural areas as well as in the conflict affected geographical zones in the country (Govindaraj et al., 2014). Nepal's health system planning is severely constrained by a shortage of health personnel – specialists, particularly staff nurses – in catering to the needs of the rural population (Ministry of Health and Population, 2014). There is an urgent need for improving skills and retaining the essential healthcare workforce, especially for care in rural and remote areas in Nepal. Studies on Bangladesh found that the major challenges for the health workforce were geographical, a skill mix imbalance, a poor work environment, inadequate managerial competencies of healthcare providers and unplanned postings and distribution (WHO, 2014, 2015b).

Apart from disparities in geographical areas and among specialists, the gender division of labour and gender hierarchy in healthcare employment leaves many of the women in nursing and allied sectors rather than being in medicine. This discrimination is apparent in the health workforce distribution in all the South Asian countries. In India, although nearly 90 per cent of the nurses and midwives were women in 2011-2012, women constituted only 27.7 per cent of all the doctors in

Figure 4.1: Female health workforce in India 2011-2012 (% per cent) Source: Rao et al.,(2016).

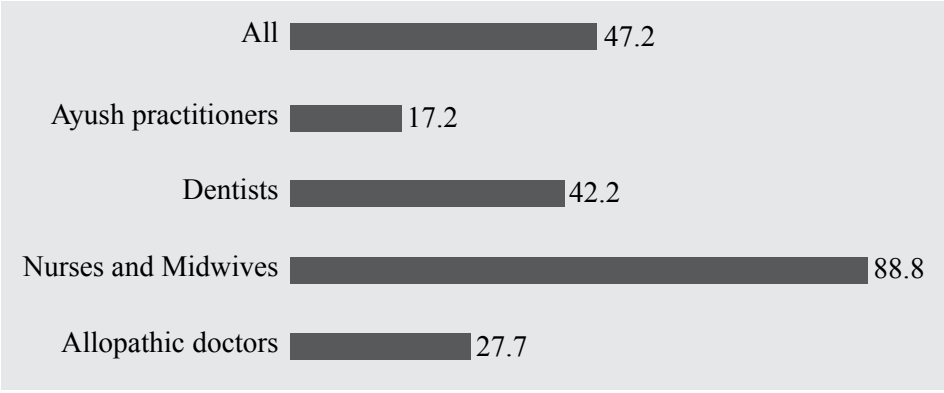
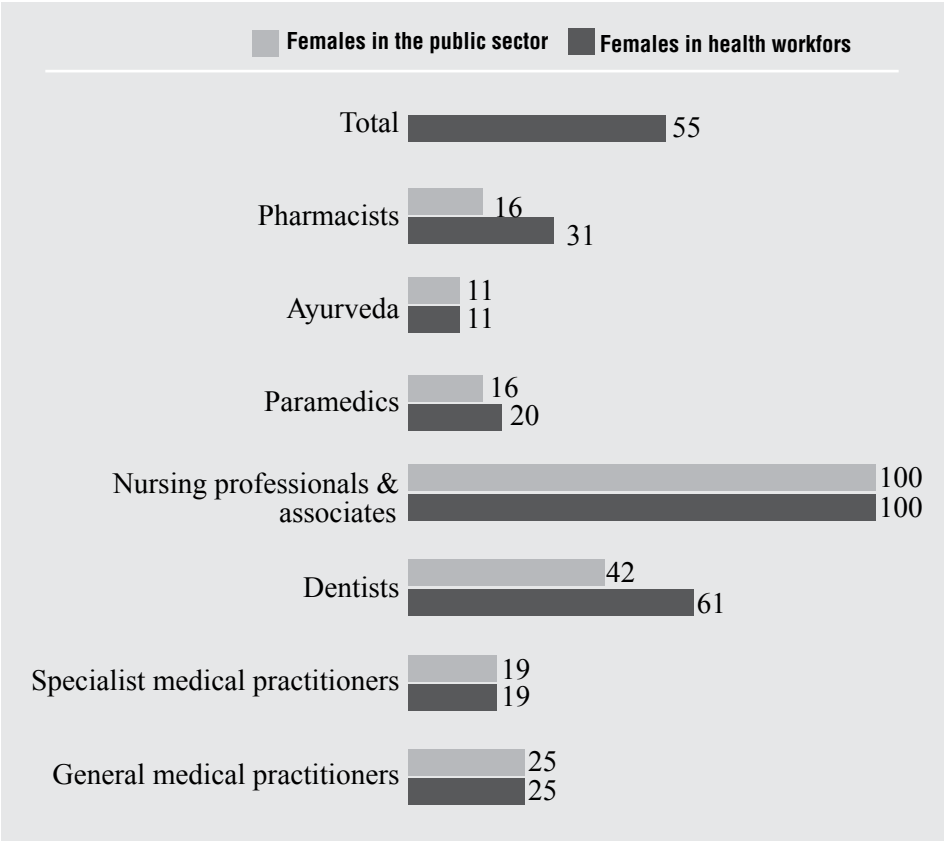


Figure 4.2: Female health workforce in Nepal in 2012 (%)



Source: Human Resources for Health: Country Profile: Nepal (2014).

the country (Figure 4.1). Obvious gender disparities in the physician workforce pushed down the proportion of women doctors in rural India to 6 per cent.

In 2005, India had only approximately seven women health workers per 10,000 population. Despite increasing morbidity among women and higher levels of maternal mortality, there were only two female doctors for 10,000 women in the country.

In other South Asian countries, including in Sri Lanka where gender parity in higher education is higher than in any other South Asian country, the percentage of women in nursing was estimated at 80 per cent or even more while women doctors constituted a low proportion; and in Nepal, despite 100 per cent women in nursing, only a quarter of the general medical practitioners were women. Notably, Nepal, with 55 per cent females in the health workforce (see Figure 4.2), had a high proportion of females health workers than India (47.2 per cent). Historically constituted patriarchal power discourses relegate women to subordinate caregivers rather than being technically and professionally qualified employees and leaders of institutions.

In short, a technically sound, competent and accessible health workforce across different social classes, castes, gender, ethnic groups and geographic regions and terrains is an essential component for equitable and quality healthcare provision. Given the multiple challenges in the prevailing workforce including shortages, mal-distribution and quality issues in the public sector, improving the health workforce in South Asia where healthcare access is a major issue, becomes imperative. As a redressal measure, apart from the very limited initiatives on formal employment generation, efforts have been made for need-based contracting of different services through public-private participation as well as contractual appointments of different categories of health professionals and ancillary workers in the public sector. Despite having a severe lag in achieving many of the millennium development goals, when we are at the threshold of the sustainable development goals, building the health workforce in South Asia becomes more complex.

CHAPTER 5

CONTRACTUALISATION OF HEALTHCARE WORK AND QUALITY ISSUES

Contractualisation of the labour force in public sector healthcare was one of the reforms implemented in the health sector in the developing world (Priya, 2005). The increased popularity of contractualisation as a reform prescription needs to be understood in its nature and the ways in which it is likely to operate. There are considerable variations in contractual labour in healthcare settings across and within countries in South Asia.In Sri Lanka, although privatisation has increased in recent decades, the government employs more than 90 per cent of the doctors and nurses in the country and provides almost all preventive healthcare.1 Often public sector healthcare providers also work in the private sector. At the central government level, contract employment in healthcare is largely limited to security and laundry services (Basu, 2016). In contrast, Nepal's healthcare is dominated by the private sector. Nepal has moved forward fast with the contractualisation of labour in healthcare, particularly of nurses and doctors as a way of addressing issues of shortages particularly in rural and remote areas, although short term contracts and high turnovers create challenges for better care (Human Resource in Health Country Profile Nepal, 2014). The burgeoning of autonomous public facilities in healthcare owing to the decentralisation policies in Nepal have led to a compromise in labour rights in the country and in the quality of services (Basu, 2016).[2]

In South Asia there are different types of contractual labour in public sector healthcare including direct fixed term contracts where workers are directly hired for fixed terms and paid by the hospital administration; daily wage earners who are hired by a hospital administration and paid by it; outsourcing a department in

1 More than 90 per cent of the in-patient care is provided by the public sector (Govindaraj et al., 2014).

2 See "Informalisation of Work: A Regional Overview" in this series.

which a service such as security, housekeeping, laundry and cateringis outsourced to a service provider (also called contracting out); and contract work in which workers are supplied by contractors/labour intermediaries who get paid by the contractors while the hospital's administration pays the labour intermediaries (contracting in, also termed as a triangular relationship by ILO).

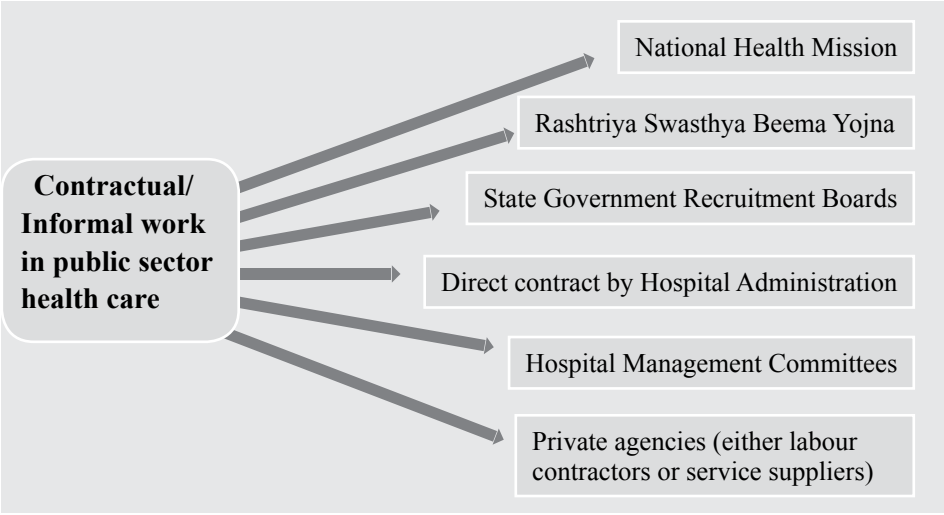
In India, various governmental agencies contract services from central government sources such as the National Rural Health Mission (NRHM, currently NHM), Rashtriya Sawasth Beema Yojana (RSBY); state government boards such as the Delhi Subordinate Services Selection Board (DSSSB) in Delhi or the Tamil Nadu Medical Services Recruitment Board (TNMSRB) in Tamil Nadu. Further, committees (with representation from the community) constituted in public sector hospitals such as the hospital management committees (HMCs) in Kerala also play a role in contracting labour to address health worker deficit. Figure 5.1 gives the different channels ofcontractual labour supply in hospitals.

Central and state government agencies play a crucial role in contractual appointments of doctors and paramedics in India. Whereas an ancillary workforce contract is more thorough, in quasi-labour intermediaries (as characterised by Barrientose 2013) workers are recruited and provided by a contractor who also pays the workers while the supervision is done by hospital managers; employment relations are unclear here. In India, massive investments have been made through NRHM since 2005 in contracting services and healthcare professionals in public sector healthcare institutions. By 2010 NRHM had appointed 2,460 specialist doctors, 8,624 doctors and 26,793 nurses in the country. Between 2005 and 2012, NRHM recruited nearly 85,368 doctors and auxiliary nurses and midwives in rural areas (USAID, 2014). Further, in an attempt to provide trained community healthcare in every village in the country, NRHM also recruited over 850,000 accredited social health activists (ASHAs).

In the process of contractualisation, the nature and type of employment and employment relations are little known. There is also a severe lack of clarity in contractualising the labour force in the public sector.

Ranadive et al.'s (2012) study on contracting private sector specialists for public sector services shows that the contract conditions did not determine the nature of

Figure 5.1: Different channels of informal/contractual labour supply in public sector hospitals in India



service delivery. Further, there was no orientation or training about contracting in or out at any level for public sector administrators and much of it depended on the leadership quality of the public sector administrators. Some of the public sector administrators feared that the stringent conditions laid down for private practitioners might further affect patients' access to services. Another fallout of contracting private practitioners for public sector services, according to the study, was drug prescription patterns as many of them were not in tune with available drugs in public sector pharmacies.

In India, uncertainty and lack of clarity persists at all levels in the processes of outsourcing where many of the non-clinical or ancillary workers are involved. In contractual appointments by the state and central government agencies (largely contracting medical, paramedical, technical and managerial staff members), despite providing better salaries as compared to other private contracting sources, employment relations are not very clear. Insecurities related to the job, skill development and career growth continue to be very high.

Notably, in India the workforce with and without written contracts increased during the two NSS periods between 2004-2005 and 2011-2012 (Srivastava, 2016).

Between 2004-2005 and 2011-2012 there was a significant increase in informal workers without written contracts in the formal sector (Table 5.1).

Table 5.1: Percentage of workers and informal workers in the formal health sector without written contracts in India (2004-2005 and 2011-2012)

Health sector (per cent)	2004-05		2011-12	
Total workers without written contracts	All employees	Regular workers	All employees	Regular workers
	47.2	45.5	49.3	48.3
Workers withoutcontracts in the formal health sector (NCEUS* definition)	32.0	30.1	41.0	39.9

Source: Srivastava (2016).
Note: *NCEUS: National Commission for Enterprises in the Unorganised Sector.

CONTRACTUAL LABOUR, ETHICAL ISSUES AND CONFLICTS OF INTEREST

Despite contracting for improving the workforce and services, several studies reveal failures in the quality of healthcare provided in terms of several of the components discussed in the earlier section on defining quality. In particular, contracting the services of private doctors has been studied in detail. Ranadive et al.'s (2012) study in rural Maharashtra on improving quality and access to services by contracting private sector specialist doctors through the Indian Public Health Standard programme for emergency obstetric care in the context of slow progress of maternal mortality reduction (much slower than what was envisaged in the MDGs), shows less promising resultsrelated to the type and nature of services provided, drug description patterns and priorities for services by these contractual doctors. The services were more suitable for elective cases than for emergencies. Gynaecologists in the private sector prioritised their much more gainful private practice than public sector emergency calls. Thus, despite spending public money for contractualising private sector physicians, quality of and access to care were questionable.

Some other studies in the global context indicate that contracting private labour was seen as an easy and often legitimate (since the care is by a private practitioner) way of increasing patients in the private sector. The hidden motive of such contractualisation is a way of strengthening the private sector at the cost of public money where the people will be the losers (Palmer, 2000). For private practitioners in India, especially for the younger ones, such contracting is a better opportunity to gain experience. Globally, more experience and training from reputed institutions were considered as the qualities of a good doctor. Thus,

often contracting-in of private services will result in an increase in the market value of the doctors rather than benefitting patients and public sector care efficiency.

CONTRACTUAL LABOUR, INDETERMINATE CONDITIONS AND EXPLOITATIVE RELATIONS

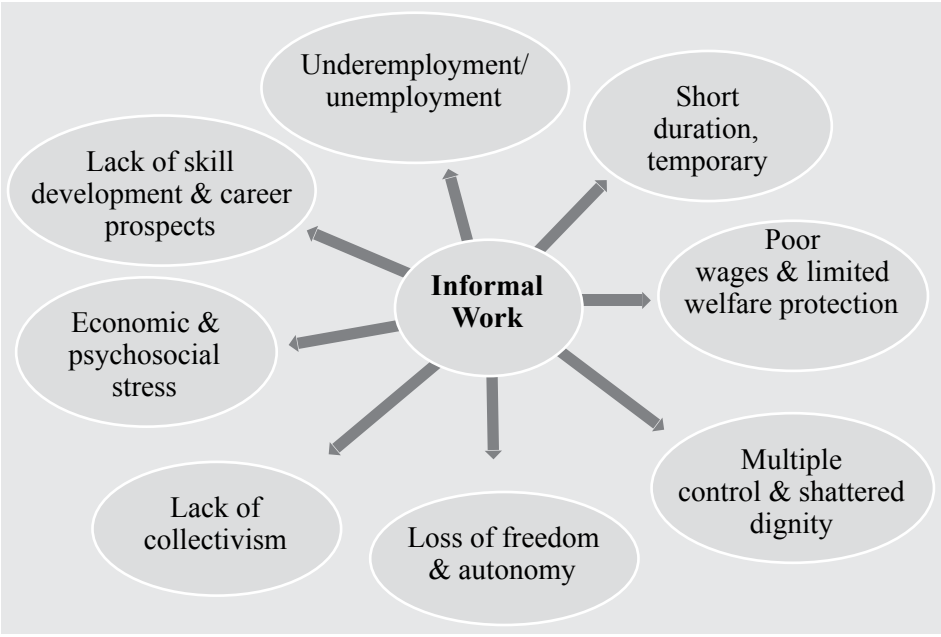
Caring for the sick necessitates a work environment conducive for nurturing a humanitarian attitude for rendering quality services. Explorations among contract workers from government hospitals under the central administration in Delhi and in hospitals in Kerala raise serious concerns about such a work environment. The narratives of paramedics and ancillary staff members illustrate the uncertainties and predicaments of contractual work as well as its implications on the structural, functional, moral and gender constructions of work.

In Delhi, paramedics were largely contracted by government agencies such as DSSSB while contracting of ancillary employees such as nursing orderlies and housekeepers, diet suppliers and security staff (both security guards andbouncers for the protection of the doctors and staff members) was largely outsourced to private intermediaries. Apart from government hospitals, Delhi has autonomous hospitals under the Government of the National Capital Territory (GNCT) where almost all postings are contractual.

In Kerala, a major chunk of healthcare professionals – doctors, nurses and technicians – was appointed on a contractual basis primarily by NRHM. Almost all the postings in NRHM, except a few on deputation arrangements from public sector institutions are non-permanent all over the country. Other sources of contracting in Kerala include HMC and RSBY. HMC, which has been strengthened following the advancement of decentralisation in healthcare largely, appoints paramedical staff including nurses and technicians and a few doctors depending on local needs; appointments of security guards are fully outsourced.Although RSBY funds are used for appointing paramedics, this is relatively limited.[3]According to one senior public health administrator most of the NRHM contract appointments lack clarity in terms, expected services and their contributions to system building. Further, some contract appointments of paramedics by the government for controlling infectious diseases were even more unclear and uncertain.

3 RSBY was not conceptualised to hire health workers, though state administrations have some flexibility in fund utilisation under the scheme. In some states such as Maharashtra, RSBY fund flows to the treasury make appointments difficult.

Figure 5.2: Characteristics of informal labour



Work and life conditions of contractual health personnel differ depending on their designation. Explorations among contractual workers other than physicians in hospitals revealedthat they were exposed to a range of adversities related to employment, although the economic situation of some of the nurses and technicians was relatively better than that of ancillary workers. A restricted number of work days/ underemployment and overtime work were some of the issues faced by ancillary workers at multiple worksites (other than paramedics) and most of them were from lower castes and ethnic groups. Among theparamedics, there was a mix of lower castes and 'others' where the proportion of 'others' was higher than their proportion among supporting employees. Figure 5.2 gives some of the important characteristics of contractual labour in healthcare.

The adversities of contractual labour include sustained threats and frequent bouts of unemployment, underemployment, overtime work for subsistence maintenance, lack of welfare protection, lower levels of autonomy (control over one's own work), heavy workload, poor sense of belonging to the organisation, lack of social support, limited social dialogue, lack of opportunities for career growth, lack of safety measures and increased exposure to psychosocial stress.

JOB INSECURITY AND DIGNITY

Unlike permanent workers, contract workers neither get a chance to represent themselves nor does the system give them fair treatment. Increasing vulnerabilities and high job insecurities for contractual workers were reported by one of the leaders of the nurses' organisation. 'When there was an error in blood transfusion which led to an adverse reaction in a patient in a hospital, the nurse on duty was summarily terminated without any inquiry. Later I was informed that some errors had occurred in the blood bank services.' This shows embedded inequalities in the informal system. Job insecurity creates stress and inhibits collectivism due to the fear of victimisation.

Abuse by authorities and stress among the workers were apparent in the comments made by nurses in an autonomous healthcare institution in Delhi where all of them worked on contract. Even though they were relatively better paid, they pointed out that strict surveillance, humiliation and insults by their supervisors publicly even for minor mistakes, which can be corrected with suggestions to concerned persons, eroded their capability to render efficient work. According to one of them, 'I am in constant tension, and not sure whether I will have a job tomorrow. I cannot enjoy life with my children and at home I cannot work and think properly because of the tensions and pressures. If am thrown out where will I go with my two children in Delhi?' Significantly, in the changing structure and employment relations in healthcare, autonomous hospitals which come under the government change/create new categories of care providers – trained nurses are posted as 'patient care executives' – which is more suited to market/corporate companies. According to the nurses, this has far-reaching implications on their career prospects. Work experience as a patient care executive is neither counted in their employment pursuits outside the country because this experience is not as a nurse, nor is continuity assured in the hospital given the contractual nature of their work. By and large, the nurses in different hospitals in Delhi and Kerala share similar job uncertainties and insecurities, although some of the conditions of work including salaries vary.

GROSSLY INADEQUATE WAGES

Experiences of ancillary staff members working as daily wagers in government hospitals are more devastating because of economic and emotional deprivations at all levels. (See Box 5.1)

Box 5.1

36-year-old Suraiah from the outskirts of Delhi has been working as a housekeeper in one of the hospitals under GNCT Delhi for the last six years as daily-wage employee on a temporary basis. Her husband is a casual labourer and her four daughters and a son study in a nearby school. Since she shifted from another part of Delhi to her current location in a basic rented house (with a rent of Rs 1,500 per month) for work and a better life, her daughters had to lose a few years of schooling before they got admitted in another school. Although Suraiah has studied a bit, her writing capabilities are limited. Her dream for her children is better education, better employment and prosperous married lives. She earns between Rs 5,500 and Rs 9,000 depending on the workdays. Her husband gets approximately Rs 5,000-Rs 6,000 a month. She cannot avail basic work entitlements such as paid leave.

While narrating the struggles of her life, Suraiah pointed out, 'During the last eight days I got work for only four days and my salary will bemuch less this month. If my husband gets work for four days, the next eight days he will not have any work or will have only limited work.' She continued, 'I am not sure how long this work will endure, termination looms. Thoughts about tomorrow worry me: How will I educate my children, feed them, continue their schooling, four of them are daughters what will I give them as dowry?'

'I don't have anybody to help me, in the hospital there is not much mutual help as the union is for permanent workers. We are poor people,some days there is no food at home and on some days we eat 'roti' with chutney,my natalfamily is poor and cannot support my children and me. We have a small piece of barren land. We might build a house there in the future. Although I am working as a sweeper out of compulsion, I like to work on all days. Now my only prayer is I should get work for 25 days in a month.'

Job insecurity, economic struggles and lack of household/social support and collective bargainingfor improving their working conditions often take a toll on the health of these workers as 'often they get ill and have depressive bouts.'A leader of the Delhi paramedical workers association also pointed out that many of the contractual workers were 'depressed.'

One of the workers (despite having a higher education background) when asked about the renewal of his contract remarked, 'I don't know what is the rule or how long it lasts, I know nothing.'

Despite all constraints and hostile work conditions, the plight of those who are recruited directly by the hospital administration is relatively better compared to those who work under a labour intermediary. The latter's work relations are

Box 5.2

20-year-old Sulabha joined a hospital as a nursing orderly through a contractor, thinking that she would be able to combine a computer course with hospital work which she thought was a 'government job.' She was misinformed that she would be getting a government job in the hospital with a salary of Rs 18,000 a month and later her post would be made permanent. Currently she gets only Rs 6,000-Rs 6,500 even though her payment is fixed at Rs 8,000, which is an amount far lower than what a permanent employee of the same rank gets. Her salary is often erratic. Rs 1,500-Rs 2,000 is appropriated by the contractor for different reasons which she does not know about. She said that she paid Rs 50,000 to get the job on the promise of a government job, a sum she got through her father's insurance.

Despite a higher workload compared to her permanent colleagues, minor mistakes invite thedispleasure of supervisors and can even cost her her employment. The humiliation and distress arising from demands for bribes from the labour intermediary who allocates their duties in the hospital is also damaging for her. Favours include getting preferred duty stations where the work burden is less, less frequent change of duty stations and even continuation of the contract.

Visibly disturbed Sulabha laments, 'When I joined work I was unaware that I was supposed to clean the workplace including the walls and windows and my payment would be this low. A woman worker here contacted my family in the same hospital who made false promises of a government job. My expectation was a computer job but I ended up in a cleaning job. I cannot bear the corruption and favouritism of the contractor who appropriates our limited salaries. Who can help me solve this problem?'

plagued with higher levels of exploitation and intimidation at multiple levels than the former's.

Despite all constraints and hostile work conditions, the plight of those who are recruited directly by the hospital administration is relatively better compared to those who work under a labour intermediary. The latter's work relations are plagued with higher levels of exploitation and intimidation at multiple levels than the former's.

Although the workers are entitled to get minimum wages according to labour laws, the contractors do not adhere to these rules and the government also does not intervene to bring them under regulations and law. Employment relations including those between a contractor and workers are very vague and many of the workers are unaware of the terms of their contract. Notably, many of the workers, especially youngsters, are being misinformed about work conditions.(See Box 5.2)

The splitting of administrative roles is evident as a labour intermediary allocates duties to a worker. The intermediary does not have much knowledge about the hospital system and the required expertise for different duty stations. This further weakens/fragments the system as hospitals require specifically skilled and trained ancillary staff members for specific services in different wards/duty stations. According to one staff nurse in charge of the emergency ward,'My trouble and burden increase with poorly experienced contractual workers.'

The experiences of workers exemplify the complexities of contractual employment and its associated adversities at work and in life including poor wages and mental and physical distress. Studies on Delhi's public sector hospitals corroborate this observation. A study on informal work in Delhi's public health system shows violations of labour standards, demoralising practices by the management and institutionalised social discrimination leading to an erosion in the quality of service (Society for Labour and Development, 2007). Another study from West Bengal (Roy, 2010) argues that apart from the exploitation of ancillary workers, outsourcing has led to a split in roles through the creation of purchasers, monitoring agents and providers. Work conditions in private hospitals are worse which neither benefit consumers nor workers. Poorly qualified and paid persons are hired as paramedics to contain costs and for maximising profits by private enterprises that further erode the quality of care (Baru, 2004).

Evidence fromacross the globe shows that downsizing of permanent labour and restructuring by contractual/informal employment have led to a complex set of adverse employment relations including overtime work burdens and psychosocial insecurities (Benach, 2010).

The work environment needs to be responsive to the needs of health personnel for improving functional quality, ensuring their technical competence and for providing them assurances and empathy.

The state's abdication of responsibility through contractualisation of public sector healthcare employment makes the work environment more fragile and hierarchical and employment relations become more unequal.

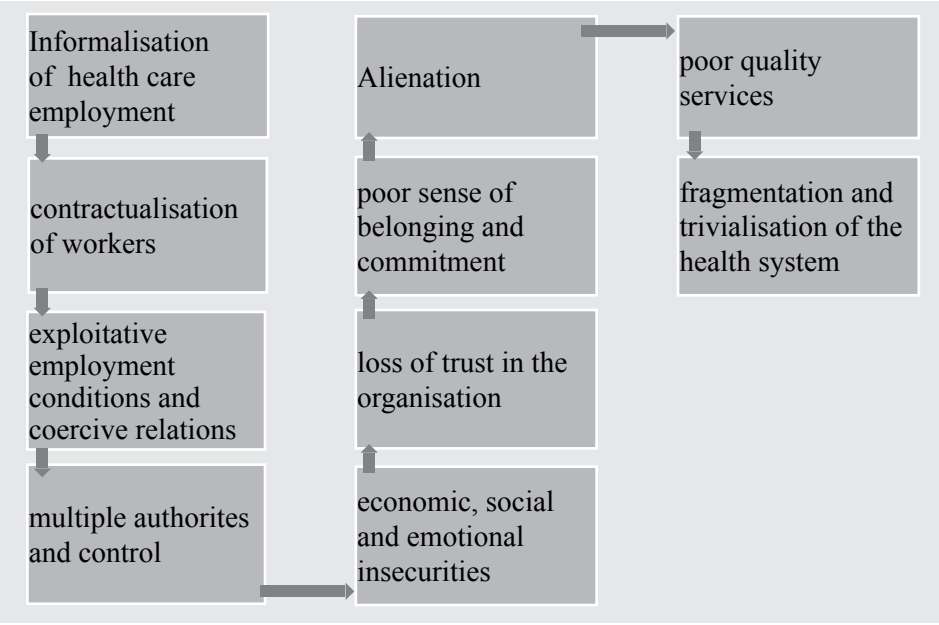
NEWER HIERARCHIES, POOR SENSE OF BELONGING AND ALIENATION

Informalisation of the formal healthcare system has created newer horizontal and vertical hierarchical relations (between informal workers and their counterparts

who are regular workers; between informal workers and supervisors/administrators; and between informal workers and the state) which often damage trust relations and the workers' sense of belonging to an organisation. While an imbalance in power and knowledge and a distinct hierarchy based on different parameters characterisethe healthcare system, mutual trust and workers' sense of belonging becomes very crucial in the effective functioning of hospitals. 'Trust relationships are characterised by one party, the trustor having positive expectations regarding both the competence of the other party (competence trust), the trustee, and they will work in their best interests' (Calnan and Rowe, 2005). A sense of belonging or an identification of the employees with the organisation can yield more organisational effectiveness.The split in trust and cooperation was apparent in the views of one of the staff nurses who pointed out,'Usually when the regular/permanent nurses protest and demand something, they get our support but our requests for such support are ignored. Last time we were reluctant to join their struggle as there was a government order banning such protests by contract workers, which severed relations between contractual and regular nurses in the hospital. We do not have any "we-feeling" at work. We are scared and we cannot afford to lose our jobs. If such a crisis occurs, nobody will be there for us, neither the regular staff (nurses) nor the government.'

Further, unfair and hierarchical relations between employees and between supervisors and employees often lead to a highly dissatisfied workforce, which in turn harms the quality of care. As one of the nursing staff members in an autonomous hospital pointed out, 'The organisation wants to terminate workers, rather than protecting them. Even for small things, they (the supervisors and administrators) are very keen to scold and punish the workers. The appraisal system in my hospital is very bad. We are forced to sign the appraisal form after leaving some blank space. We are not sure what they write in the blank space. I cannot trust them. There is enormous tension. After spending several young and productive years of my life in this hospital, they will throw me out like a curry leaf. I never feel it's my institution. Since I am crossing the age for a permanent government job, I am terrified that things may really go bad for my family including my school going children.' This distrust and dissatisfaction often creeps into the quality of their services. According to one employee, 'I try to provide maximum care. Still there are times when I cannot provide service satisfactorily.' There is growing evidence to show that in South Asian health systems caste, class and gender intersect in the hierarchy of work, whichaffects trust relations among and between providers (Baru, 2005; Qadeer, 1985).

Figure 5.3 : Pathways of informalisation of employment affecting the quality of service and trivialising the healthcare system



Contract workers are forced to accept covert and overt coercion at different levels owing to compulsions. Lack of freedom, intimidation and fear among the workers was apparent in the interviews. During one interview, a young worker felt uncomfortable during the conversation and whispered,'I am scared to talk,'and pointing to another worker added, 'That woman is close to the supervisor (labour intermediary), if she says something to him my job will be in trouble.'

One of the contractual workers opined, 'we are not free to air our opinion or protest for rights. Authorities have issued an order banning protests. Our supervisors also will not take any such offense lightly.'

One of the studies on the health system in Kerala shows that managerial/ functional inputs, which are parallel to the general health system with a separate administrative mechanism, increase the trivialisation of health services. They also create newer power loci and divide authority, which fragments the health system and hampers efforts towards integrated care (Jagadeesan, 2013).

Lack of freedom, loss of trust and poor sense of belonging arising out of hierarchical and coercive relations often lead to lack of commitment and have a

negative impact on organisational involvement among workers. This results in higher levels of alienation among the workers, as seen in their perceptions. Etzioni (1975) and Lunnerberg (2012) maintain that when coercive power is applied by an organisation it creates hostility and the involvement of the workers becomesalienative. Workers maintain that lack of opportunities for dialogue, fears and anxieties often make them feel isolated, powerless and estranged, although many of them value their work as meaningful. As one of the non-clinical workers working on a Sunday said distressingly to a question on not wearing a uniform, 'Despite hard work, the work here in this government hospital is only a label. There is no uniform or identity card. I would have felt proud and powerful with an identity card. I wear whatever is available at home.'

MULTIPLE AUTHORITIES, POWER RELATIONS AND FRAGMENTATION OF THE SYSTEM

In changing labour market relations and employment scenarioshospitals have become a battle ground for an array of authority and power equations both vertically and horizontally. Authority, according to Weber, 'is the probability that a given command with content will be obeyed by a person or a group of persons.' Power is the 'probability that one actor within a social relationship will be able to carry out his will despite resistance, regardless of the basis on which this probability rests.'Power is related to the personal characteristics of individuals or groups, while authority is related to social positions and roles and it is a legitimate relation of domination and subjugation. With the accentuated importance on 'managerial' aspects and contractualisation of different categories of workers/supervisors, new managerial/supervisory authorities have emerged in public sector hospitals. For instance, NRHM has appointed new managerial staff members including district programme managers (DPMs). According to a hospital superintendent, 'The workers posted under NRHM in the hospital are supervised and managed by the DPM.' DPM does not have any links to the administration and functioning of particular hospitals and power clashes are not uncommon.

Further, with the intensification of contractualisation new power centres of labour intermediaries have been created within public hospitals. Ancillary staff members have to face dual control by health professionals and the labour intermediary who is in charge of their duty allocation in the hospital. Such multiple controls and authorities within the same institution create fragmentation of the system and physical and mental stress among workers.

Contractualisation of labour raises corrupt practices at multiple levels. Corruption and nepotism exist at the higher levels of administration, as one of the public health professionals mentioned, 'in terms of recruitment and in continuation of contract.'At the workers' level (largely owing to poor payments), as one of the nurses put it, 'for "chai-pani" (tea and drinks), usually the ancillary workers take bribes from the patients and monthly they earn an amount equal to that of their salary through bribery.'

Besides this, contractualisation also raises new questions on accountability and transparency as well as ethical and moral dilemmas.One of the health workers, also a workers' union leader said, 'If something goes wrong due to negligence or an error by a health personnel, who will be responsible or how will he/she be accountable? Any day they can leave or their services can be terminated.'The dimensions of moral and ethical dilemmas in the system increase as happened in the case of a pregnant lady doctor on a contractual appointment who was forced to leave her job due to her inability to keep hospital timings and daily routines because of problems associated with her pregnancy.

The impact of informalisation of employment on the quality of healthcare and subsequent fragmentation and trivialisation ofthe systemis multifaceted and complex (Figure 5.3).

This makes a strong argument for a permanent workforce with enabling work conditions for improving the quality of service and health outcomes.

CHAPTER 6

CONCLUSIONS

The downsizing and restructuring of the health and employment sectors in South Asian economies in the last two decades of the 20th century and the decades of the 21st century has pertinent implications for the labour economy, workforce and health systems. All the South Asian countries including Sri Lanka, which is among the good-health-at-low-cost countries with solid public sector healthcare, have deficits and inequalities in the health workforce, particularly accessibility and availability of a qualified health workforce across geographical regions, terrains, castes, gender and ethnic groups. Experiences from hospitals in Delhi and Kerala show that contractualisation of the health workforce for increasing 'efficiency' hasnot led to desired outcomes. On the contrary, poor work conditions and multiple authorities have considerably weakened the principles of equity and fairness in labour, impaired skills and led to a less committed workforce, fragmented the system with multiple power loci and authority and subsequently raised the threats to the quality of care. It has also created newer moral and ethical dilemmas in healthcare employment with limited spaces for collective voices, welfare protection and organisational dialogues. Job insecurity, inadequate wages and wage theft are matters of concern. Historically, the private sector was required to follow the public sector for good quality employment by following legislations for protecting employment and ensuring quality. The current transformations with poor employment relations in the public sector health system, therefore also have the danger of legitimising the private sector's irregularities and exploitation.

Despite having a politically vibrant population and a strong trade union movement, Kerala is not very different. The self-concealed and politically ignored nursing employees' fight for their rights is apparent in their unionisation efforts since late 2000s after decades of exploitation (Biju, 2013). It seems that their unionisation efforts strengthened when the capital's subtle recognition of dehumanising interests of profit accumulation through the neoclassical assumptions of altruism and principles of morality, gender, service and religion were shared and reinforced by the state, employers and also often by political parties.

In India during the early post-independence decades, improving the quality of employment in terms of increasing wages and minimum social security were major concerns in employment rather than a limited perspective of employment generation as the relatively faster economy envisaged in the Five-Year Plans was expected to generate adequate employment (Papola and Sahu, 2012). Thus, in contemporary South Asia improving quality as well as employment generation in the formal sector became challenging.

Government health expenditure in South Asian countrieshas been abysmally low. In 2014, Pakistan ranked the lowest in government health expenditure as a percentage of gross domestic product (0.9 per cent) followed by India (1.4 per cent), Sri Lanka (2 per cent) and Nepal (2.3 per cent), whichis much lower than the WHO recommendation.

Apart from policy implications for health systems, this study's findings also have important implications for labour unions in South Asia. It raises a crucial question of unionising the contract workforce and improving work conditions and commitments. Another crucial question is that of the role of unions of permanent workers.Unfortunately trade unions in South Asia are hardly equipped to meet the challenges of exclusion of labour policies (Henk, 1996) and the erosion of commitment among the permanent workforce, although trade unions in the region have a history of nearly a century. India's recent Supreme Court judgment that contract workers should get the same pay as permanent workers heightens expectations. Learning lessons from history, trade unions will have to develop innovative strategies, approaches and programmes.

RECOMMENDATIONS

- Demand sufficient state investments for standard employment (including regularisation of contractual workers) in public sector healthcare to rectify the deficit in the health workforce and inequalities in healthcare accessibility.
- Work towards introducing measures to strengthen the health system; contractual workers' economic and welfare benefits should be made equal to those of regularised workers.
- Ensure legal protection for contractual workers at all levels including for their rights, work standards and improving the quality of work conditions through enforcing strict regulations and criteria for contractual recruitments.

- Advocate for appropriate amendments of the laws, policies and programmes that at the moment lead to exclusions of workers' welfare protection and safety.
- Demand effective measures for equitable workforce distribution, particularly to meet the health needs of populationsin backward and remote areas, women, low castes and ethnic groups as well as for building equity in developing the health workforce throughadequate representation of these populations inmedical and paramedical education.
- Demand a reorientation of medical and paramedical education focusing on the health needs of different populations with an emphasis on the attitude, trust relations and commitment required for healthcare employment.
- Work towards the complete exclusion of labour intermediaries in public sector healthcare while short-term contracts by governmental sources may be reduced to a minimum just for a transition period with very clear criteria and conditions of employment to make the system more efficient and effective.
- Create general and legal support groups to respond to rights' violations and for personal and professional needs.
- Promote women's participation in collective processes and in leadership roles.
- Conduct continuing education programmes for all categories of workers including contractual workers forskill and career development and also for personal development.

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Public Services International, South Asia
61, I block, Sector 10, Faridabad - 121006, Haryana, India
website: www.world-psi.org