Class and Gender Dynamics of Outsourcing Manpower in the Health Sector
From Formal to Informal work

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Estimates by academicians have pointed out that salaries appropriate as much as 70 – 80per cent of state budgets, leaving a minuscule share for health infrastructure and other inputs. A solution to the problem has been offered through reforms which have propagated alternative mechanisms of recruiting workforce. These include hiring staff on short-term renewable contracts and outsourcing tasks to a contracting agency. The following paper is a case-study of a tertiary-care hospital which has adopted such hiring practices.

This study on contract-hired and outsourced workers aims at documenting the dynamics and implications of reforms in recruitment on the conditions of work of those recruited on such work arrangements, and on the quality of healthcare.

This paper draws on a larger qualitative study which examined the implications of health reforms for services provisioning within a tertiary -level government hospital. Between September 2016 and June 2017, in-depth interviews were conducted with 85 health workers including both permanent and casual staff. Prior consent from the Delhi Health Department was solicited for conducting the study.

Reforms in recruitment have advocated outsourcing for the lowest rung of employees, while for technical, nursing staff and physicians, the system of contracts has been introduced. Both groups of workers were paid lower than regular employees carrying out the same tasks and had to contend with long-term job insecurity. However, the experiences of outsourced workers revealed a more humiliating working environment. The process of 'casualization' of workforce showed a class dimension, further marginalising the already vulnerable sections of society. Also, it was women from the groups who were concentrated in the lowest paid jobs.

There appears to be class, caste and gender-based discrimination of employees in the health sector through contracting and outsourcing.

Keywords : health reforms, contracting, outsourcing, feminization of work, public hospitals, India

Since the 1990s, economic reforms aiming at fiscal discipline have seen many governments try various strategies to reduce health expenditures. These reforms were based on the tenets of improving efficiency, effectiveness, and quality of care in public health services. Besides, reforms often presumed a more dominant role for the private market in healthcare financing, provision, technology, and research. Advocates for privatisation/outsourcing argue that a distinction should be made between the provision of public services and the production of public services. The former is

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seen as an example of government responsibility, and the latter is viewed as best left to the private sector. This view of the state as 'enabler' rather than 'provider'underpinned outsourcing in health policy (Lochlainn & Collins, 2015, p.2).

The present paper focuses on human- resources -reforms that have aimed at reducing the burden of salaries in India's health budget. Estimates by academicians have pointed out that salaries appropriate as much as 70 – 80per cent[1] of state health budgets, leaving a minuscule share for health infrastructure and other inputs. The high proportion of budget claimed by salaries has not prompted an increase in budgetary allocations for healthcare, which remains at a dismal 1.1per cent of GDP[2]. On the contrary, there is evidence that cost-cutting measures are being implemented. Such measures include a slowdown in permanent recruitment and stepping up of alternatives like contract hiring and outsourcing of health personnel. Through these measures, the government has reduced its obligations of paying salaries on par with the market, and of pension payments.

The idea of outsourcing public health services had its roots in the paradigm of New Public Management (NPM). Hodge (1999) describes outsourcing as stemming from the privatisation movement, particularly in the US and the UK. In the UK, introductory competitive tendering was a key component of the Thatcher government's privatisation programme[3] (Lochlainn & Collins, 2015, p.1). NPM was a market-driven model, where quality, costs, and efficiency, ensured by competition between providers and informed consumers, was the formula to ensure the optimal provisioning. Public sector bureaucracies were regarded as bulky, corrupt and resource- inefficient. Although public servants and bureaucrats did not have a profit motive, they were perceived to be fulfilling self-interest, which came in the way of public or national interest (MacDonald, 2010, p. 27). NPM is also called the "public choice" approach, which offers competition with private providers as the solution for attaining efficiency in the public sector, disregarding the inherent differences between the public and private sectors.

Another dominant approach, the transaction costs (TCE) suggests that activities which are frequently conducted and exhibit high degrees of uncertainty and asset specificity have high transaction costs which are likely to exceed the benefits of transacting. They are therefore best produced in-house. Activities that incur low transactions costs are outsourced. Following this strategy, core functions of patient- care are retained within government production and provision, and it is the ancillary services that have been outsourced.

The present paper draws its data from a qualitative study carried out by this author, on implications of health reforms within a tertiary hospital in New Delhi. The study brings to fore the plight of those who work as a contract or outsourced workers, and documents clear discrimination of lower class and women employees, who perform non-clinical work such as cleaning and sanitation, laundry, catering, ambulance drivers, security guards and nursing orderlies.

[1] As reported in 'The Hindu' dated December 1, 2016, "Wages and salaries account for 86per cent of the total public expenditure in Punjab, 72per cent in Maharashtra, 65per cent in Kerala, 52.5per cent in Madhya Pradesh and 35per cent in Odisha"

[2] India's low allocation for health is in sharp contrast to high-income countries, where health reforms have a deep penetration, and yet allocations to healthcare are very high. Of the total health spending in India, the Indian government contributes just 29per cent. In the UK, the government's share is 83per cent. For others, this figure ranges between 45 and 55per cent

[3] As early in 1982 we find evidence of Health authorities introducing competitive tendering for support services, such as catering, cleaning, portering and estates maintenance in the NHS, United Kingdom

The paper is divided into five sections. Following this introductory section, the second section presents the study methodology. The third section describes the dynamics of working as contracted and outsourced workers through experiences of employees. The fourth and fifth sections contain the discussion and conclusions, respectively. These sections are enriched through excerpts from interviews[4] conducted by the researcher which bring out the real picture of contracting and outsourcing, as experienced by different categories of hospital staff.

Methodology

The larger qualitative study that examines the implications of health reforms for services provisioning within a tertiary level hospital was designed as an institutional ethnography of a tertiary hospital under the Delhi government. We aimed to draw on the perceptions and experiences of hospital staff to understand how health reforms have impacted the employees, and service provisioning. Essential areas of reforms within the hospital -setting included computerisation of all hospital departments and systems, user fees for specific services and procedures, reforms in the recruitment of health personnel, outsourcing of ancillary services, and public-private partnerships in the delivery of certain core functions.

Selection of the hospital: Since the study aimed at documenting changes brought about through health reforms, we needed hospitals that were functioning before the reforms, i.e., earlier than the 1980s. Of the four hospitals, the present hospital[5] was selected on the basis of convenience for conducting an ethnographic study. The study hospital is a 714- bedded super- specialty tertiary hospital with seven clinical and five para-clinical departments. The ease of getting permission from the hospital director and Medical Superintendent also aided in the choice of this hospital where resistance was minimal.

Prior written consent was solicited for conducting the study from the Health Secretary of the Government of Delhi. Individual consent was taken from all participants before conducting the interviews. Unstructured in-depth interviews with all categories of hospital staff – doctors, nursing staff, technical staff, nursing orderlies, and cleaning staff, as per the terms of their contract, i.e., permanent, contracted, privately outsourced, was done.

Sample size and selection: A total of 85 hospital employees were interviewed between September 2016, and December 2017[6], including permanent, contracted and outsourced staff. Of the 85 employees interviewed, 45 had permanent government jobs, 20 were on one-year renewable contracts, and 20 were outsourced employees. The selection of employees was through snowballing, more often depending upon their willingness to be a part of the study. Most government employees had inhibitions in consenting for interviews, as their service contracts rule against sharing of official information with outsiders. We, therefore, maintained the complete anonymity of participants. Observation of the day-to-day activities of the hospital supplemented the data collected through interviews. The researcher had long and in-depth informal conversations with union workers and leaders on the issues of contract-hiring and outsourcing.

[4] In the quotes used for description Cleaning staff has been denoted by CS, Nursing orderly by NO, technical staff by T, Nursing staff by N, and Doctors by D

[5] The name of the hospital has been concealed for maintaining the anonymity of respondents.

[6] Further interviews were conducted from August 2017 till December 2017, and a total sample of 156 hospital staff had been interviewed for the larger ethnographic study.

The researcher also visited sites of protest and observed their meetings, where informal conversations with members from other hospitals helped to understand the magnitude of the issue. It was through these meetings that the researcher met union members of ASHA workers' and Anganwadi workers' unions, who had been demanding regularisation of their employment. The section on feminization was brought to limelight through these informal meetings on how mass casualization of grassroots female workers has happened during the last decade. Since these interviews were informal and unplanned, they have been supplemented through review of the literature, which remains very scanty. The present paper thus builds from the data collected within the hospital but can capture the trends of casualisation of labour beyond the hospital boundaries through literature emanating from workers' groups, newspaper reports, and a few published studies.

The inspiration for the present study comes from the scarcity of studies on reforms and their implications in healthcare institutional settings such as hospitals. Most research on reforms discusses the concepts and critiques them. However, studies examining the implementation of reforms and the every-day manifestations of reform, remain very few. This paper focuses exclusively on human resources reforms in the public health sector, where we identify newer recruitment modes of outsourcing and contract employees.

The present study uses Yeheskel Hasenfeld's conceptualisation of healthcare facilities as human services organizations, which are unique, as 'people' are their raw materials – both in the form of service providers and patients to be worked upon. Organisational effectiveness is a function of the complementarity and congruency between the goals of the organisation and personal needs of the workers. (Hasenfeld, 1992, p.27) This implies that if the personal needs of the staff members are not met by the organisation, and when they are dissatisfied with their job, they will take it out of their clients. This approach thus holds health workers as central to the health seeking experience and views health reforms critically for the divisions it has created in public health workforce.

Dynamics of contracted and outsourced work: A critical inquiry

Before the 1980s all staff was permanent - selected either through Union Public Service Commission (UPSC) or Delhi State Selection Board (DSSB). The outsourcing[7] of services in the study-hospital was first initiated during the 1980s with the outsourcing of cleaning services. The hospital has gradually privatised security services, laundry, cafeteria, ambulatory services (contracted out) and deployment of nursing orderlies (contracting in). The outsourced workers are recruited and remunerated by a contractor – selected through a tendering process for a fixed budget. In both these forms, the responsibility of the government as an employer becomes minimal. They have no liability to provide any social security or job security cover, or pension. According to its advocates, outsourcing allows the government to retain overall control over the quality of service through contract specification, monitoring, and evaluation of performance. Unlike the privatisation of assets, outsourcing is easier to reverse (Lochlainn & Collins, 2015, p2).

For all other employees, the Delhi government has since the late 1990s introduced recruitments through temporary contracts instead of permanent selections. Initially, these recruitments were seen

[7] The Eighth (1992–1997) and Ninth (1997–2002) Five Year Plans introduced the system of contracting out of primary level services, and consequently, in the Tenth (2002–2007) Plan, there were talks of both contracting in and contracting out of clinical and non-clinical services. (Basu, 2016). However, these strategies were already in experimentation, and here we find outsourcing of cleaning services had begun in the 1980s

as temporary measures to meet the hospital requirements until the permanent selection process was conducted by UPSC/DSSB. However, since the late 1990s, DSSB has also hired hospital employees on contract basis at all levels of the hierarchy. Within these arrangements, the employees are recruited for a fixed term of 11 months, at a fixed monthly salary. The system of contracts carries no allowances, or pension- cover. The first batch of contracted staff in the selected hospital was recruited in the year 2003, and the practice continues till today.

In this section, we describe the results of our interviews and observations with contracted and outsourced workers and their colleagues within the study hospital.

Contractual workers: Working as a contract-worker was revealed to be an exploitative experience. The remuneration scales of contract staff were remarkably low when this system was initiated, finding parallels in the private sector. For example, when contract nurses were first inducted, their salary was fixed at Rs 6,000 per month. This was later increased to Rs 11,000 per month, and finally to Rs 16,000 per month through successive pay commissions. However, when a large number of contract workers united, they filed a case against the discrimination by Delhi Government and made the demand of "equal pay for equal work." This was premised on the logic of the same quantum of work being done by contract staff as permanent staff, while differential salaries were being paid. In a landmark October 2016 judgment, the contract workers won their demand, and their monthly salary was increased at par with the basic salary of permanent staff, which is now Rs 45,000. This has led to a significant boost in morale of contractual staff. However, there are a few categories of contract-staff who do not come under the purview of this judgement. Also, other postulates of the contract, i.e., a fixed term of 11 months, no allowances, no promotions, no pension, leave disparity, etc. continue.

The dynamics of insecure jobs affect contract-staff considerably. Not knowing how long the system of contracting would be practiced, whether and how it would be discontinued, and for how long they would have to continue performing the same tasks because of no promotional avenues, were sources of worry for all contractual employees. In the private sector, contracts are the normal form of recruitment, and all staff is employed under the same contract rules. In the study hospital, the experience of being a temporary worker was heightened due to the presence of permanent peers, who worked without any worries. One Assistant professor (doctor) who had worked on contract in the past said (D3, Personal communication, October 15, 2016) –

> "The contract system is abusive. There is nothing for the employee – no quota of leaves, dismal salary structures, and no scope for the future. I used to be very depressed when I was working on a contract. I was so uncertain about my future (thinking about)– how long will I continue like this, or what will I do if someday my contract is not renewed."

Contract-staff also reported that they were often exploited. For example, a contract- staff nurse is expected to do all the work that a permanent nurse performs. Both contract nurses and permanent nurses have the same or equivalent qualifications. However, contract nurses had a much greater workload because permanent staff would leave their share of work for their contractual counterparts to carry out. Most permanent staff were reported to keep themselves occupied with administrative work, leaving patient -care to contract nurses. As one of the contract nurses (N27[8] , personal communication, January 25, 2017) shared:

[8] To maintain the anonymity of hospital employees, they have been denoted by a reference code for all personal communication

> "Since our jobs are not secure, we cannot say no to any task. However, permanent staff nurses have no fear of anyone. They conveniently ask us to take care, while they do their work. And we can't even complain, because we fear that if our report shows negative remarks, our contracts may not be renewed next time."

The general perception about contract workers was very negative. They were seen as outsiders, and not as part of the system, and often excluded from social forums and discussion groups, leading to their alienation. The contract staff is popularly characterised by the permanent staff as temporarily placed, and not belonging in the hospital. In the words of a permanent staff nurse (N2, personal communication, October 21, 2016) - "Today they are working here, tomorrow if they find a better job, they will go there." Since their jobs are not permanent, it is presumed they don't develop a sense of belonging to the hospital.

The permanent staff – whether junior or senior, appeared to assume superiority over contract staff. They expected the contractual staff to demonstrate respect and do as they were bid by the permanent staff. Because promotional avenues are reserved for permanent staff, there is a strong notion that only the permanent staff would continue in the hospital in the long run. As a consequence, senior staff attributes greater credibility to permanent junior staff. A Nursing Sister said (N22, Personal communication, December 13, 2016):

> "We cannot leave the responsibility of handling high-end-equipment to contract- workers as we have found them very careless in their approach. Since the accountability for all stock and machines lies with me, I have to be careful in distributing the work. I can be questioned if anything goes wrong. They have nothing to lose; their jobs are already contractual."

The consequence of these dynamics was multiple hierarchies being created within hospital wards and departments, where all permanent staff emerges as one cohesive group. The contract staff often lacked solidarity, and they were unable to trust even other contract staff. There is a constant fear of negative reporting, even from fellow contract workers. As one contract staff nurse shared (N27, Personal communication, January 25, 2017):

> "I can't talk to any of the nurses the way I am talking to you. They don't spare any chance of complaining about us and becoming good in the eyes of seniors."

The dynamics of interpersonal relations varied with different occupational groups. Among doctors, there is absolute disenchantment with the system of contract hiring of doctors, and the remuneration is seen highly inadequate[9] They not only feel it as discriminatory but also counterproductive, because doctors hired on a contract never stick to their jobs. All the permanently employed doctors who we interviewed, felt highly protective of the few contract doctors, whose productive years were seen as wasted. A contractual position for a doctor is seen as a temporary job taken by either women doctors who have home responsibilities and therefore cannot fulfil the job obligations of the private sector, or by doctors who are just waiting to find a better job. An interesting comment was made by a senior professor (D20, personal communication, January 31, 2017):

> "if a contract doctor is sticking in the hospital for a long time, then you can infer that he is not a well-trained doctor; doctors with a sound background will find a better job very soon".

[9] Contract doctors receive Rs 63,000 per month. Senior residents doing their Masters get close to Rs 1 lakh. Thus more qualified doctors get paid lower than students who they have to supervise.

Administratively, the induction of employees on differential contracting terms has led to a fragmentation of authority and accountability systems; creating operational problems in governance. Since there are no clear rules for the protection of contract -staff, and because there is no contract- staff at senior positions to speak out on their behalf, they become answerable to permanent staff across the hierarchy, who were often biased in their opinions about contract-staff. Functionally authority becomes distributed to the lowest levels of permanent staff, and abuse from junior permanent staff was also shared.

Outsourced staff

Outsourced staff members faced a double burden of authority as they had to report both to the hospital administration and to the contracting agent. Constant and strict surveillance; poor pay; denial of fundamental rights to safety at work; humiliation by permanent staff across all levels of the hierarchy, and insults by their supervisors publicly for minor mistakes eroded their capability to render efficient work.

Outsourced cleaning staff earned RS 13305 per month and an outsourced nursing orderly earned RS 13584 per month. The corresponding basic pay of permanent staff was RS 35000-40000 per month. Outsourced workers do not even have a union to voice out their concerns. In the words of the Supervisor (Supervisor of Contracting Agency, Personal Communication, May 15, 2017) –

> "They will be removed by the contractor if they engage in union activities. Who will listen to them?"

Interviews with outsourced employees revealed that often there was not even a written agreement between the contractor and the workers, which led to discrimination and human right violation. The conditions of work are poor, and the salary paid is low. The contractor may replace a worker at any time, delay payment of salaries, and often.

Their vulnerabilities and exploitation are demonstrated in the following episode shared by the outsourced cleaning staff. For many months the outsourced cleaning staff was not given a salary, as the contractor had himself not received his payments from the Delhi government. When there was considerable delay in government payment continued for a lengthy period, the contractor made all the outsourced employees sign a statement declaring that they were willing to wait for their salary till the contractor received his payment, and in case he did not, the workers would not demand any money from him for the services they had rendered. As a fallout, many outsourced workers left the job.

Another serious discrimination reported by the outsourced cleaning staff was the denial of Hepatitis-B vaccination, which is administered to all permanent cleaning staff once in three months. Exposure to Hepatitis B Virus is an occupational hazard for all healthcare workers. However, cleaning staff are at a higher risk since they deal with hospital waste, and can be exposed to contaminated needles. Outsourced cleaning staff in the study hospital had been denied this preventive cover despite repeated requests. According to the Supervisor from contracting agency, the hospital administration was unwilling to spend the RS 5000 per outsourced cleaning worker required for the vaccination.

Harassment by permanent staff was a regular feature in the lives of outsourced workers. The following is an account by outsourced nursing orderly: (NO5, personal communication, May 11, 2017)

> "Working side by side with a permanent orderly is in itself a demeaning experience, as he can say anything to me. Whether he is present or absent from workstation, it does not matter, but the nurse in charge will question me for everything".

An outsourced cleaning staff member shared (CS2, Personal Communication, August 22, 2017)

> "If the permanent orderly is not present, the nurse will not bother, rather ask me to do his work as well. The nurses make us do any work they require – bringing tea from the canteen, getting photocopies from outside, etc. Even changing patient bed sheets, and patient's urine bag – which is strictly a nurse's job. But since we have to work with them, we have to comply with all their demands. If someone says no to such tasks, they will pick the phone and complain to the supervisor – what kind of person you have posted here, how he can argue with us. So we are like their servants."

The management of outsourced work also becomes very tedious. This is because functionally, the hospital administrators are responsible for ensuring that the work is done, but they lack any authority over outsourced staff or the contractor. Union members told this researcher that the contractor showed a higher number of employees on paper than those deployed by him (T2, Personal Communication, September 12, 2017) –

> "He will get all the work done by less number of persons, so these workers are overworked. But he will claim the salary of all persons on paper. So that amount gets pocketed by the contractor."

Discussion

The exploitation and discrimination of workers through contract-hiring and outsourcing have been voiced through writings of trade unions.[10] The authors of a study noted how the restricted career growth, high turnover, and low salary of contractual staff in comparison to regular colleagues working in the same organization for the same purpose has led to a conflicting environment in organizations (Kumar & Khan, 2013, p.67). The 2009 Comptroller and Auditor-General (CAG) report on NRHM highlighted significant staff shortages despite contract recruitment and pinpointed to the difficulty in retaining contract workers as a crisis in the system. Despite these observations, there has been no change in the processes of contract recruitment.

The main consequence of these newer modes of recruitment has been large-scale casualization of health workers, and their deployment in the informal economy. The workers employed through outsourcing and on contracts have temporary jobs with no employment guarantee, no promotional avenue, or any long-term wage security. This creates immense psychological stress for workers who are always conscious of the insecure nature of their jobs. Far from the government's promises of job creation in the formal economy, we find a significant number of posts which were already regular being transformed into temporary positions. While at one level this amounts to a violation of workers' access to government jobs, it does more damage by justifying the 'hire and fire' practices of the private sector by emulating them.

Two important and inequitable consequences of the human resources-reforms merit detailed discussion. These include the disproportional impact of the human-resources reforms in the health sector in Delhi on the poor and Dalit populations, and on women.

[9] Public Services International (PSI) is a global trade federation represented by over 700 unions across 154 countries. PSI released a Booklet series on Healthcare Workers in South Asia titled - Non-Standard Work in the Healthcare Sector in South Asia.

Marginalising the marginalised – bearing a greater load of cost-cutting practices

The outsourcing of non-clinical activities shows clear discrimination against lower class employees, who are seen shouldering a greater burden of these cost-cutting strategies. All non- clinical activities – namely cleaning and sanitation, laundry, cafeteria, security guards, ambulance drivers, and nursing orderlies come under Group D employees, the lowest in the bureaucratic hierarchy. And it is precisely these services which have been handed over to the private contractors. The employees who took these jobs came from poorer households and often had only 8 to 10 years of schooling. One cleaning worker appointed through outsourcing shared how they are trapped because of limited job opportunities (CS6, personal communication, 24th August 2017)

> "We have to fill our children's hunger, and so we are working like this. Otherwise, there is no respect, no status. I couldn't complete my education, so this is my only option. I have been working like this for the last seven years, and not once any permanent vacancy has been announced. The earlier generation of cleaning staff was lucky; they got permanent jobs."

Many of the cleaning and sanitation workers were not only financially poor but belonged to socially disadvantaged sections, as cleaning and sanitation work is caste-identified in the Indian society. The supervisor of the outsourcing agency reported that 90per cent of the 216 outsourced cleaning staff belonged to the Valmiki community (Supervisor of Contracting Agency, Personal Communication, May 15, 2017)

> "No one else comes for this work - it is only Valmiki people who do this work. The remaining ten percent are from very low-income families and willing to do any work".

Thus, the loss of permanent government jobs through outsourcing has systematically excluded the socio-economically disadvantaged sections of society. The permanent jobs provided an avenue for better financial security to these marginalised sections, as well as health benefits, improved access to better nutrition for women and girls; increased the chances of a girl child completing elementary schooling and an overall general upward mobility through respect achieved with the status of a government job. As shared by a permanent nursing orderly (N01, personal communication, October 18, 2017) –

> "My daughter is doing graduation from Delhi University; she is the first in my family to achieve this. Not even boys of our community study this much. I wanted her to become a nurse, but she wants to become a teacher."

Permanent government jobs were a more important type of positive discrimination compared to quota reservations for SC, ST, and OBCs as it employed unskilled work – largely fulfilled by persons from socially backward sections who could not complete schooling or technical education. Permanent government jobs made it possible for the subsequent generations from these families to compete for higher services, which is now lost altogether. Interviews with outsourced workers revealed how present incomes were insufficient to fulfil the needs of a family. In most cases, these incomes merely support family incomes earned by the workers' fathers or brothers engaged in alternative work like farming or some petty business. A few outsourced employees came from far off places, often from neighbouring states by travelling a significant distance up and down, as their salaries could in no way pay the rents of the national capital (CS1, personal communication, 22nd August 2017) –

> "It is impossible to run a family on this income. My brothers are engaged as agricultural labourers; together we can meet the ends. When they don't have work, our entire family of eight manages in my salary. Sometimes we have to borrow even for meeting daily expenses."

The reason for outsourcing non-clinical work, according to retired directors of the hospital, was excessive union activities, leading to disruption of hospital work. Recurring protests by Group D staff crippled hospital functioning, and a complete solution was sought through privatisation of such services. This is why outsourcing of cleaning work happened much earlier in 1980 (in the present hospital) while contracting began in 2000. However, the shift to outsourcing merely reflects government's apathy towards the needs of Group D employees, since trade union participation was always strong among public health workers. Unions for doctors, nurses and technical staff still engage in protests when their demands are not addressed by the administration. Outsourcing of ancillary services has iniquitous implications for the already less skilled and marginalised workers.

Feminisation of low paid work

The general trend towards hiring temporary workers for public health has at one level discriminated against the lower level employee. But at another level, we chart a higher proportion of women occupying these low paid positions. In the hospital where the study was conducted, there were only two doctors on contract, who were both women. Even among pharmacists, dieticians, social workers, a significant number of female staff had been appointed on contract. Looking beyond the hospital system, at the level of primary care a significant number of women have been deployed without fixed salary structure. These include the large army of ASHA workers, who have constantly been demanding regularisation and a fixed salary. The National Rural Health Mission (NRHM) introduced ASHA workers in 2005 as honorary volunteers with a provision for performance-based-compensation for work like assisting a low-income woman for institutional delivery and collecting samples for different tests. Their job requirements are not only physically demanding but often pose security threats to these women, who have to make regular home visits. As Nanda comments, this kind of volunteerism perpetuates the perceived low status of women workers within the system since an overwhelming majority of male staff belong to the salaried group. (As cited in Baru, 2005, p. 283)

After ASHA workers, ANMs and Anganwadi workers constitute another army of women workers who have been denied the rightful compensation of their labour – and are now constantly negotiating with the governments to increase their salaries. The trio of ASHA, Anganwadi workers, and ANMs have been most important in India's achievements on Infant mortality and maternal mortality rates, but this trio has also been most neglected and victimised - their conditions exemplify gross feminisation of lowest paid work. Informal interactions with members from these groups revealed the extensively laborious nature of their work which requires them to visit each home in the village, participate in the census and other government programmes, and frequent exposure to verbal abuse and harassment they endure in fulfilling their duties. In return, they don't even get paid government-prescribed minimum wages, rather a meagre honorarium.

Rama Baru who presents a synthesis of studies on conditions of health workers finds that most of these workers come from the poor socioeconomic background.

> … a majority of these workers are women belonging to the lower class/caste combine. An important reason for choosing women of this social background was that women belonging to upper castes would rarely participate outside their houses. Thus one sees that social hierarchy both in terms of caste and gender play an important role in the choice of female health workers [...] the working conditions and wages earned by community-level workers are poor. They are often paid only an honorarium that barely covers their travel costs. (Baru, 2005, p. 283).

She further quotes a 1995 study by Iyer, which reported that while ANMs may belong to upper and middle castes, they were not from landed sections. About 64 per cent of ANMs belonged to landless and poor peasant families. (as cited in Baru, 2005, p. 292)

Thus, here gender combines with class and caste to produce systematic discrimination of women and their labour. In the tertiary hospital where the present study was conducted, interestingly not a single outsourced cleaning worker was a woman. On probing, it was revealed that there were instructions from the hospital authorities not to appoint women workers, because they take more leave of absence. Thus, women suffer on all counts – they are discriminated in getting work, ghettoised in casual or informal occupations, and lastly, denied ethical compensation of their labour. As Amiya Bagchi asserts, with globalisation, all labour has been casualised in larger proportions, but the intensity of casualization has been even greater among women. (Bagchi, 2004, p.11).

Conclusions

Outsourcing and contracting are both fraught with serious violations of workers' rights and dignity. Greater workload accompanies intense job insecurity as there are no avenues for growth, either professionally or financially. It is interesting how contract positions for doctors become smart choices for entry into better jobs, while this advantage is lost to other contract workers. At the lower end of the bureaucracy, outsourcing has become a trap. The exploitation of lower-level workers is intense.

The processes of contracting and outsourcing have produced a staggering array of different terms and conditions under which the three-tier workforce is functioning. At one level it creates operational problems due to multiple layers of administration, control, and governance. It also forces workers with different entitlements to work together, making hospitals into spaces where exploitation becomes institutionalised, and there is little scope for workers' empowerment.

When we take note of the population groups who are engaged in contract and outsourced jobs, the caste, class and gender-based exploitation associated with these 'human-resources' reforms become evident.

The most ironical aspect of these reforms is that despite having initiated outsourcing and contracts for more than 15 years, recent estimates continue to show the high proportion of salaries in government budgets. Evidence shows increasing salary slabs of the residual permanent staff through successive pay commissions. R. Nagaraj's analysis, using data for six years from 2005–06 to 2011–12, shows that during this period, for all categories of central government employees, on average, real wages rose by 7.9 per cent per year – compared to per capita income growth of 6.8 per cent per year (Nagaraj, 2017, p. 165). Thus, human resources reforms have merely removed the lower hierarchy, and the white collar continues to absorb more benefits.

A serious inquiry is needed into the human-resources-related reforms which are translating into iniquitous structures within institutions. Government jobs and institutions, which were means for empowering the society, have become spaces where the marginalised become further excluded, and their exploitation becomes normalised. As C.U. Thresia writes introducing unequal labour standards and dividing the workforce within an organisation and the system threaten the concept of

building an integrative, social- development-oriented workforce and health development. (Thresia, 2016, p. 11)

Note: The figures for salaries of permanent and casualised staff pertain to the hospital where the interviews were conducted. These vary across centre/state, across state governments and also according to the level of care – primary, secondary and tertiary.

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