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The Paradigm shift in Public health: A Socio-Legal study of Public and Private Healthcare Services

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Abstract
Health care system in India is under transition. In the first phase (1947-1983) major achievements were eradication of smallpox and plague, reduction in Maternal Mortality Rate, reduction in Infant Mortality Rate, containment of cholera and increase in longevity to almost 54 years. During this phase 100% government personnel's were involved in public health care delivery system. In second phase (1983-2000), major emphasis was on National Health Programme implementation under vertical model, framing of National Health Policy (2003) and initiation of private partners started in family planning services in limited numbers. During this process of structural change thrust was that, not to fill up the vacant posts after retirement or superannuation. Such types of arrangement have resulted in chronic shortage of human resource at every level. World Health Organisation (2006) reported that there is a shortage of health workers with an uneven distribution of human resources, particularly in developing countries. India is listed among countries with a critical shortage of health manpower. The broad status of contractual model as demonstrated in the review of literature reveal that it needs serious overhaul of policies about the implications of implementations for quality of service conditions in the health services sector. However human resource factors like job security, career development, motivation, commitment for the organization, which play vital role, are not understood properly under new structural changes under health care system in India

Introductioncy (2003) and initiation of private partners started in family planning services in limited numbers. During this process of structural change thrust was that, not to fill up the vacant posts after retirement or superannuation. Such types of arrangement have resulted in chronic shortage of human resource at every level. World Health Organisation (2006) reported that there is a shortage of health

In the recent decades the demographic transition, fast growth rate of older people, longevity and changing profile of diseases from communicable to non communicable have posed a serious challenges to the health care system across the world. The change in the system is inevitable, its needs urgent attention and recognition. The present health care system in India is completely based on Bio- medical model. The current health practices focus heavily on the medical supply side. The escalating pressure on health systems is to reduce, ration, and delay health services to contain health costs (Bandura 2005), which operates on the three key concepts: disease, diagnosis of disease and treatment. It completely overlooks the preventive and promotive dimensions of health. The present article how ever does not focus on conflict between different models of health care. It rather concentrates on structural changes in health care system, likely to affect health care functioning in future. How new model having inherent latent motives to reduce the burden of the state are being designed and implemented, and what could be implications in future. The first step that India adopted with the implementation of new liberal economic policy in the health sector was to reduce the human resource size of those on regular basis. New economic stringent measures adopted in India are: not filling the post on regular basis, not filling the post after superannuation. It has led to "structural changes in the human resource". To understand the changing human structure in the health system, its brief background is discussed as follows:

Pre-liberalization: In the Pre-Independence phase, the country did not have many 'Public Sector' Enterprises like Railways, the Posts and Telegraphs, the Port Trusts, the Ordinance Factories, All India Radio, Government Salt Factories, Quinine Factories, etc. which were departmentally managed. Independent India adopted planned economic development policies in a democratic, federal polity. The Nation was facing problems like inequalities in income and low levels of employment, regional disparities in economic development and lack of trained manpower. India at that time was predominantly an economy based on agriculture with a weak industrial base, miniscule level of savings, inadequate investments and infrastructure facilities. The capital was scarce and the base of entrepreneurship was not strong enough. The planning process (five year plans) was initiated taking into account the needs of the country. The new strategy for the public sector is outlined in the policy statements in the years 1973, 1977 and 1980.

Emphasis on public human resource: After independence of India the emphasis was more on "developing public human resource" at the state cost and nurtures them for implementing the government schemes. The health care system demanded elephant size of human resource from district to the village under primary health care system. However it has been suffering a lot in the absence of adequate number of human resource required to implement national health programmes.

During the first phase (1947-1983), under Primary Health Care System, despite scarcity of human resource country achieved commendable success as listed in the table no 1. It reflects towards team spirit of public health resource of that

time. Motivation, dedication and commitments superseded the contracts of different nature which are attributed to underutilization and dysfunctional status of health care system of today. The first phase was completely on the shoulders of public health personnel. The second phase inducted partnership of private partners in a very limited manner; and in the third phase onwards the structure of public health system has undergone sea changes under flagship programme of NRHM, changes in the structure of health care system looks that there is conscious effort to institutionalize the new structure which will have dominant share of manpower under private mode.

Table1. India's health care services during different phases

(India' Health System, NCMH 2005)

Major Achievements	Remarks

First Phase (1947-1983)
• Health policy was assumed based on two principles:
  ○ None should be denied care for want of ability to pay
  ○ It was the responsibility of the state to provide health care to the people.
• With meager resources, effective containment of malaria, bringing down the incidence from an estimated 75 million to less than 2 million
• The eradication of smallpox and plague
• Reduction of maternal mortality
• Reduction in infant mortality from 160 per 1000 live-births to about 105 per 1000 live birth.
• Containment of cholera and increase in longevity to almost 54 years.
	• These gains were in no small measure and were due to the professional cadre of public health specialists
	• Leading from the front, camping in villages in hostile environmental conditions, to eradicate smallpox or supervise the malaria worker. [22]
	• Scarcity of resources and hostile environment were superseded by professional commitments, morale, motivation of public health personnel from top to bottom.

Second Phase (1983-2000) • First National Health Policy (1983) • Encourage private initiative • Access to publicly funded primary health care was expanded • Expansion of health facilities for providing primary health care in rural areas • Implementation of National Health Programmes (NHPs) • Vertically designed and centrally monitored structures • Innovation and experimentation for increasing accountability and efficiency in resource use • For meeting the growing demand for hospital care, substantial subsidies were extended to the private sector.	**Remarks** The twin strategy however failed due to serious omissions in public policy: (i) the failure to establish a regulatory framework and accreditation processes for governing the private sector; (ii) the absence of a surveillance and epidemiological system resulting in poorly designed health intervention (iii) inadequate investments in developing skilled human resources.
Third Phase (Post-2000) • This phase has witnessing a further shift which has potential to profoundly affect the health sector in the country in three important ways: (i) the desire and need to utilize private sector resources for addressing public health goals (ii) liberalization of the insurance sector to provide new avenues for health financing (iii) redefining the role of the state from being a provider to a financier of health services as well.	**Remarks** • Principal challenge for the health system continues to be the improvement of the health status of the people in a sustained manner. • Quality and reach to people remained challenge. • Under utilization of facilities emerged as challenges.

Access to medical care continues to be problematic due to important social determinant of health e.g. transport facility, education facility, difficulty in accessibility leading underutilization of the existing health infrastructure at the primary level contributing to avoidable waste (NCMH Report 2005). The reasons for under achievement of health goals can be attributed

to three broad factors: (i) poor governance and the indifferent role of the health care machinery of state; (ii) lack of a strategic vision; and (iii) weak management. The structural non-adjustment in the institutions at the Centre and State levels, with many departments and agencies duplicating work or working at cross-purposes make governance in health ineffective. Contributory factors for a dysfunctional health system are non evidence- based goal-setting, lack of strategic planning and inadequate funding, centralized decision making, poor management of resources such as irregular supplies, large-scale absenteeism, absence of performance-based monitoring and conflicting job roles making accountability problematic. As per Rural Health Statistics (2010) there are 640 districts, 4510 Community Health Centres, 23391 Primary Health Centres and 145894 Sub-Centres in India.

Liberalization: The year 1991 is termed as the watershed year, heralding liberalization of the Indian economy. It launched its market-oriented economic reforms evolutionary and incremental in nature. There have been delays and reverses in some areas due to the interplay of democratic politics, coalition governments, and pressure groups with vested interests (Charan and Wadhva 1994).

New economic policy under the influence of globalization demanded different models of human resource in every sector. This has demanded reduction in the state burden as it is the crucial feature under new alternative models to fill the deficiency. The revenue deficits reflected an excess of annual consumption expenditure by the government over its annual income. The deficit was caused by excessive employment in the government sectors, uneconomical pricing of goods and services by public sector enterprises, a growing interest burden, mounting subsidies, and rising defense expenditures. To begin with, downsizing the government (through the bureaucracy or public sector enterprises and banks) was difficult and it received huge staff resistance from the organized employees. However, over the years pay-for-performance philosophy has become reality and new HR trend emerged (Charan and Wadhva 1994).

New economic policies demanded different models of human resource in social sector to which health is a part. In brief the policy emphasized on the restriction on filling the post after superannuation, shortage of human resource aggravated due retirement of more and more regular employees, organizations started suffering more in terms of manpower and deficiencies in functioning become more and more deeper. Thrust has been more on “economic models” having lesser burden on organizations. The new economic policy of 1991 has serious implication for both quantity and quality of employment (Singh 1993). It is very much reflected in skills, knowledge & attitude of health care providers. Thus emphasis on capacity development increased, leading to increase in the training budget. Different models of employment emerged during the last one and half decade, Public Private Partnership & Contractual employment to reduce the economic burden of the government. Differences in terms & conditions of various forms of employment have resulted in various human resource management issues which have even resulted in legal actions. All models of human resource hiring are in place and different types of manpower have different effects on motivation and satisfaction level of employees. Today, both Public Sector & Private Sector have become an integral part of the economy. Under these models many research issues have emerged like how contractual model is operated? What is the human resource policy regarding contractual system? What is the satisfaction level of human resource (Regular & Contractual) under health care system? What is level of the job/organization commitment of different types of human resource under health care system? What could be new human resource initiatives which may lead to increase in satisfaction level, career development of human resource which may result more organizational commitment. Whether government decisions for hiring of human resource under contract, thought economical, would serve real purpose of providing quality service to the people?

Scientific understanding of efficacy of different models of human resource under primary health system is crucial issue for achieving the health goals. The legal and administrative implications of temporary and contractual employment arrangement are scientifically unknown. This has led to restricted career growth, low motivation, high turnover, reduced training & development, improper utilization of skills, low salary in comparison to regular colleagues, less commitment. Increased number of temporary human resource may pose threat to sustainability of health care system. The attitude & behavior of such workers is crucial to organization performance & quality of service provided. Before any model is institutionalized in the country at macro level we need to understand the constraints embedded into it. Constraints related to human resources in the health sector are a hindrance in achieving the health related goals (Wyss 2004). World Health Organisation reported that there is a shortage of health workers with an uneven distribution of human resources, particularly in developing countries. India is listed among countries with a critical shortage of health manpower (World Health Report 2006). A growing concern over the poor outcomes in the health status when compared to the amount of resources spent has forced many countries to introduce reform measures in their healthcare systems. Efficiency is sought to be achieved by decentralisation, outsourcing and privatisation. However, in most cases, health sector reforms have mainly focused on a single objective of reducing the government’s expenditures (Lethbridge 2004).This narrow focus on cost containment has lead to a situation where human resources are seen as a cost rather than as an investment. As a result human resource costs have been targeted for expenditure reductions (Bach 2001). This has resulted in changes in the numbers of permanent and temporary staff in public sector healthcare organisations (International Labour Organization 1998).

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Globally, there has been continuous growth of nonstandard work contracts (i.e. contracts which deviate from the standard contract form, which is full-time, permanent and relatively secure). In many developing countries, the recruitment process is often plagued by considerable delays. There is an increasing use of temporary contracts to overcome the delays in hiring process (World Bank Report 2009). The use of various forms of temporary employment contract has fragmented the workforce. Human resource management is crucial to the success of such reform measures (Nigenda and Gonzalez 2009). Therefore, it is important to consider the implications for the human resources at an early stage in the reform process.

Temporary Human resource's perspective: Before any postulate is made and hypothesis are developed and tested with ulterior motive, theoretical frame is drawn, and assumptions become full-fledged rules of laws, it is necessary to know what researches reveal. There are considerable differences in work conditions in different types of temporary jobs. The contracting process is viewed ambiguously by health workers. Several studies have documented the negative effect due to contracting and due to the workers response to such work conditions. This may lead to strained labour relations and labour conflicts (Martineau and Buchan 2000). The legal and administrative implications of temporary employment arrangements with doctors engaged as employees in the public hospital system are generally poorly understood by hospital administrators (Skinner et al 2006). Temporary employment contracts have been found to lead to absenteeism, restricted career mobility, worsening of work conditions, reduced training and development opportunities (Kolehmainen-Aitken 2004). One such stipulation of labour laws that might be of concern guarantees a permanent position in the civil service after a certain period of service under contract in the public sector (World Bank 2009). Increasing number of temporary doctors poses a threat to the sustainability of the hospital medical workforce, improper utilization of skills of contract workers, low motivation/morale of the workforce, and higher turnover. Various studies have reported salary and other benefits differences between various forms of contracts with terms being mostly unfavourable for temporary contract workers. Low salary has been noted to be a major demotivator for public sector health employees (Ravindran and Sood 1996).

The health managers' perspective: On the managers' part, there is a lack of clarity on new roles and responsibilities, and inadequate training to cope with peculiar human resource management issues. There is a need for a clear vision of how the reform process would affect the human resources and to deal with such issues. A breach of the psychological contract may elicit negative attitudinal consequences like job dissatisfaction, and produce negative work behaviours like lower commitment and turnover intention (Bal and Vink 2011). From an employee's perspective, the psychological contract guarantees job security, and fair wages and benefits. A breach occurs when the employee experiences a discrepancy between his/her own expectations and the actual fulfilment of obligation by the employer. The type of contract can moderate the relationship between employment status and outcomes like job satisfaction, organizational commitment and turnover intention.

Various studies regarding temporary employment's effect on job satisfaction and organisational commitment have shown varied and inconclusive results (Connelly and Gallagher 2004). Job insecurity is inherent in temporary employment arrangements. A temporary employee working in a "non-preferred" type of contract may exhibit poor organisational attitudes. Job characteristics relate to job satisfaction, organisational commitment and turnover intension. Unequal compensations in different forms of employment contracts may lead to dissatisfaction with the job, lower commitment and intention to leave. Therefore, adverse job outcomes related to the different types of employment undermine the very purpose of the health reforms. Doctors are not just healthcare workers; they also fulfil the role of managers and leaders in healthcare organisations.

The importance of human resource policies for improving the performance of health system has been highlighted in recent years (Joint Learning Initiatives 2004). Contractual Character of Employment under NRHM is now being associated with an increasing number of problems. Renewal of contracts, poor service conditions and increments, high turnover rate, reluctance to send them for longer skill-based training and unnecessary and retrogressive hierarchy between the contractual and the permanent staffs are some of the problems. Report talks about that there should be proper HR policy for human resource under contract. States needs to create posts for contractual employees, pay differences should be minimized, supportive environment should be provided to the staff (CRM 4th Report, 2010).

The public sector enterprises have generally been construed as 'model employers' and they used to employ the brightest people in a very fair selection process and generally through a open competition model. The jobs in public sector always used to be the most preferred, by educated middle-class, and the talent was generally given its due respect in the public sector. However, the situation has changed in the last 10 years Earlier there was little opportunity available for professionals to migrate from one organization to another, but during the last decade ample opportunities have been opened up for them to leave the organization. To add to this, the demand for talent is not confined to any particular sector of industry but the professionals are moving across sectors. As a result, public sector is under huge pressure in terms of attracting and retaining talent.

Health Sector and Public-Private Partnership: Having realized the dominant position of the private sector, the Government has, of late, made efforts to engage with the private sector in providing services under the National Health

Programmes with the primary objective of expanding access. Government efforts to collaborate with the private sector have been programmatic, sporadic, disjointed and tentative, and not the result of a well-thought out strategy aimed at achieving national health goals. In the absence of any evaluation of these arrangements, it is difficult to assess their utility or impact on Government budgets. This is important in the light of the negative experience of incentives given to private hospitals, such as excise duty exemptions, free land, etc. in lieu of treating 10% of inpatients and 40% of outpatients free (Public Policy Response, NCMH 2005). The conditions laid down by the Government were not adhered to by any of the recipients of such government subsidies. Such public-private collaboration will continue to engage policy attention and is justified on the basis of resource limitations for expansion to meet the growing demand. There is, however, a need to undertake operational research and analysis of the cost-effectiveness of contracting the private sector, given the fiscal position, for example, the implications to government finances and the potential for litigation due to any contingency where government is unable to pay its dues as per contract on account of an adverse financial situation. In such a situation resources may have to be diverted from public facilities to fulfill contractual obligations. However, such policies will have to be within the context of a regulatory framework and provisioning of financial risk protection. Health care delivery requires a health system that stands on the three pillars of a professional human infrastructure, a rational, efficacious and affordable drug regime and easy access and availability to appropriate technology. It is these three inputs that drive up costs and need regulation and control (Public Policy Response, NCMH 2005).

The road and way forward: Ever since the process of economic reforms was launched in India in 1991, employee healthcare reforms became a part of the government's national socio-economic agenda. In addition to the involvement of the public and private sector corporations, various government, international and multi-lateral health agencies, and other private stakeholders such as private health insurers got involved in the reform process. However, till today one of the handicaps faced in the path of employee healthcare reforms has been the lack of sufficient evidence based information about, and the impact-assessment of various initiatives (such as Balika Samriddhi Yojana, Nutrition Program for Adolescent Girls, Maternal Health Program, etc.) undertaken as part of the reform process. Looking into this weakness, the Ministry of Health and Family Welfare in conjunction with the World Health Organization (WHO) Country Office has undertaken a review and documentation of these initiatives in India. This is an long drawn and continuing review process that started in 2004.

Building a health system for improving health in India, Improving health in India will require the building up of the health system in the next ten to fifteen years based on certain core values. Five concerns emerge when facing the challenge of improving health in India: (i) promoting equity by reducing household expenditure in total health spending and experimenting with alternate models of health financing; (ii) strengthening public health infrastructure and restructuring the existing primary health care system to make it more accountable; (iii) reducing disease burden and the level of covariate risk; (iv) initiating and implementing institutional frameworks for improved quality of governance of health; and (v) investing in technology and human resources for a more professional and skilled workforce and better monitoring. The unpredictability of illness, the lumpiness of health consumption, and the irregular and seasonal nature of incomes make it virtually impossible for the poor to finance their health needs, resulting in a denial of care and greater poverty. It is unacceptable that poor households spend substantial amounts on services that ought to be freely available under the National Health Programmes. Second, while preventive health care leads to improved health of the population over time, in the short term, access to curative services is essential for limiting the associated income shocks and preventing progression into poverty on account of unexpected hospitalization or prolonged illness. In other words, the poor can be expected to comply with low-cost preventive behaviour (washing hands with soap/using a bed net) as it is within their realm of control but cannot afford the hospitalization in times of emergency, and losing their lives in the process. This then shifts the burden of responsibility to the society for providing treatment to those who have no means.

In health sector, contractual employment is well accepted and recognized concept. All the National Health Programmes are hiring human resource on contract basis. Contractual model initiated because of foreign funding policy. Under RCH-II programme hiring of specialist on full time or on part time was the necessity of the time. In some states private practice is permitted and scarcity of human resource in health always exists. As of now no solution is feasible, lot of medical colleges and institutions are coming up due to systemic compulsion. Under contractual hiring of doctors and paramedical staff quality of health care is important issue. Lot of cross examinations is needed. The scientific status of where we stand is not available; all opinions exist on the basis of theoretical assumptions and speculations only. As Common Review Commission (2010) 4th report talks about low motivation and improper handling of HR issues at the state government level under NRHM though out the country.

Under modern HR perspective in private sector mangers and leaders are working towards goal directed behavior. In private sector Mangers are taking care of personal needs of employees, their motivation level, their satisfaction level. But in health sector health personnel are dealing with human beings, where along with medical care human touch is also required. Therefore health sector is unique and different from many other sectors, dedicated provider are key in success.

Overall, the principal challenge for the health system continues to be the improvement of the health status of the people in a sustained manner. Despite States attempting several innovations, the health system continues to be unaccountable, disconnected to public health goals, inadequately equipped to address people's expectations and fails to provide financial risk protection to those unable to access care for want of ability to pay. Despite huge investments in expanding access, a villager has to cmmute over 2 km to reach the first health post to receive a mere tablet of Paracetamol; more than 6 km for a blood test and nearly 20 km for comprehensive hospital care. It is estimated that 25% of people in MP and Orissa could not access medical care due to location reasons, while it was 11% for UP (India's Health System NCMH 2005 Report). On an average one Sub-Centre covers 5049 persons (Rural Health Statistics, 2010), so total population which is covered under Sub-Centre is 73.66 crore means 40% of population is deprived of even fractured health care system in India. Further, even when accessed, there is no guarantee of sustained care. Several other deterrents such as bad roads, the unreliability of finding the health provider, costs for transport and wages foregone, etc. make it cheaper for a villager to get some treatment from the local quack. What are the reasons that led to such failure? Essentially three broad factors: poor governance and the dysfunctional role of the state; unrealistic goal-setting and lack of a strategic vision; and weak management.

The reforms in health sector employees remain a sensitive issue. As the Director General of the WHO commented, 'dealing with issues such as pay and incentive in the public sector… constitute some of the most challenging items on the International health agenda' (Bach 2001). Poorly management of human resource in health remains the most challenging constraint for health sector reform. In major part of country the problem with shortage, misdistribution with poor utilization of human resource remains prevalent. Even if HR is available that is not utilized to their optimum skill. The universal reforms in health sector have raised many HR challenges. In labour intensive human resource service industry the quality of service is linked to skill, motivation and commitment of staff providing the service. The uncertainty and intensive working pattern associated with working pattern have badly affected the staff morale. The three broad conclusions can be drawn on effective HR strategy from the research evidence:

Ownership; people are regarded as strategic resource and nurtured along with mangers that support such approach. External Fit; organizations with effective to HR are alert to external environment, planning their HR requirement in a manner that incorporates the changing HR implications with reference to external environment and resolve the problems. Internal Fit; this refers to approach to HR policy which is not over reliant on one element (e.g. training) but combines HR policies into integrated bundle policies and practices.

Although efforts are being undertaken for health sector reforms but insufficient attention is given to HR for health management issues. Policy makers have been overly optimistic that once the plan for reforms has been devised the process of implementation will be relatively straight forward. There is long way to develop effective HR policy in health, never the less simple measures will be more effective if they tackle the simple problem of health workforce like recruitment, selection, salary, training and career growth in the organization. However, if we draw a comparison between the developed economies of the western world, India has to travel a long way to go in terms of employee healthcare. There are various inherent weaknesses in the national health policy. For instance, providing employee insurance cover for health is not a mandatory requirement in the private sector in India till now. Many experts treat it as a fundamental weakness of the healthcare system in India which needs to be addressed urgently. Reforms in this area will pick up more paces when the government provides incentives and imposes stricter regulations on the employers in both public and private sectors in India. There is a real need for human resource development (HRD) policies related to recruitment, promotion, transfer and training (NCMH Report 2005).The demoralization and demotivation that exists among the workforce must be countered by enhancing professional competencies and career opportunities the system is likely to suffer from required skill mix and in particular public health expertise is hindering us from achieving national health goals. Therefore to understand all issues critically we need to go in background around which the health care system has emerged.

References:

- Bandura A (2005): The Growing Centrality of Self-Regulation in Health Promotion and Disease Prevention. The European health psychologists, September issue 1. http://www.ehps.net/ehp/issues/2005/v7iss3_Sept2005/EHP_Sept05_Bandura.pdf
- Bach S (2001): HR and new approaches to public sector management: improving HRM
- Bal P, R Vink (2011): Ideological currency in psychological contracts: the role of team relationships in a reciprocity perspective. The International Journal of Human Resource Management: 1–24.
- Capacity. Prepared for the Global Health Workforce Strategy Group, World Health Organization. Geneva. Viewed on 15th December 2011,
- Charan D, Wadhva (1994): Economic Reforms in India and the Market Economy (New Delhi: Allied Publishers), Ch. II.
- Charan D, Wadhva ed.1977: Some Problems of India's Economic Policy (New Delhi: Tata McGraw Hill). Available at

http://www.apcss.org/Publications/Edited%20Volumes/RegionalFinal%20chapters/Chapter16Wadhva.pdf Viewed on 7th November 2011.

- Common Review Commission 4th Report 2010. Ministry of Health and Family Welfare Government of India, Nirman Bhawan, New Delhi.
- Connelly C, D Gallagher (2004): Emerging Trends in Contingent Work Research. Journal of Management; 30(6):959-983.
  http://www.who.int/health-servicesdelivery/human/workforce/papers/HR.pdf
- India's health system: The financing and delivery of health care services. National Commission on Macroeconomics of Health. Available from http://www.whoindia.org/LinkFiles/Commision_on_Macroeconomic_and_Health_Section_2.pdf viewed on 17th December2011.
- International Labour Organization (1998): Terms of employment and working conditions in health sector reforms. Report for discussion at the joint meeting of employment and working conditions in health sector reforms. International Labour Office, Geneva. http://www.ilo.org/public/english/dialogue/sector/techmeet/jmhsr98/jmhsrr.htm
- Joint Learning Initiatives (2004): Human Resource for Health overcoming the crisis, Harvard University's Global Equity Initiative (GEI). Washington, D.C.
- Kolehmainen-Aitken (2004): Decentralization's impact on the health workforce: Perspectives of managers, workers and national leaders. Human Resources for Health, 2:5. http://www.human-resources-health.com/content/2/1/5
- Lethbridge J (2004): Public sector reform and demand for human resources for health (HRH), Human Resources for Health, 2:15 doi: 10.1186/1478-4491-2-15. http://www.human-resources-health.com/content/2/1/15
- Martineau T, J Buchan (2000): Human Resource and the Success of Health Sector Reform. Human Resources for Health Development Journal. 4(3). http://www.moph.go.th/ops/hrdj/hrdj11/HR-success-Tim.htm
- National Commission on Macroeconomics and Health (2005) Report. Ministry of Health and Family Welfare, Government of India. Available at http://www.whoindia.org/LinkFiles/Commision_on_Macroeconomic_and_Health_Executive_Summary.pdf viewed on 10th December 2011.
- Nigenda G, L González (2009): Contracting private sector providers for public sector health services in Jalisco, Mexico: perspectives of system actors. Human Resources for Health, **7**:79 doi: 10.1186/1478-4491-7-79. http://www.human-resources-health.com/content/7/1/79
- Public policy response: Public-private partnership. Available at http://www.whoindia.org/LinkFiles/Commision_on_Macroeconomic_and_Health_Section_2.pdf viewed on 10th January 2012.
- Ravindran P, AK Sood (1996): Job satisfaction of staff nurses working in a large metropolitan hospital. Health Population: Perspectives & Issues, April-June; 19(2): 89-95
- Rural Health Statistics (2010), Ministry of Health and Family Welfare, Government of India.
- Singh S (1993): New Economic Policy in India: Some Implications for employment and Labour Market, IJIR, April; 28(4).
- Skinner C, R Riordan, K Fraser, J Buchanan, K Goulston (2006): The challenge of locum working arrangements in New South Wales public hospitals. MJA,185: 276–278.
- World Bank Annual Report (2009). Washington, USA.
- World Health Report (2006): Working together for health. 1211 Geneva 27, Switzerland.
- Wyss K (2004): An approach to classifying human resources constraints to attaining health-related Millennium Development Goals. Human Resources for Health, 2:1. Doi: 10.1186/1478-4491-2-11. http://www.human-resources-health.com/content/2/1/11