Health Policy and Planning, **39**, 2024, 1055–1064
DOI: https://doi.org/10.1093/heapol/czae085
Advance access publication date: 26 August 2024
Original Article

Changes from initial Posting to subsequent Posting and Transfer: a frontline perspective from India

Bhaskar Purohit [1,2,*] **and Peter S Hill** [3]

[1]Peter Faber Business School, Australian Catholic University, Building 532—Tenison Woods House, 8-20 Napier Street, North Sydney, New South Wales 2060, Australia
[2]Department of Health Policy and Management, Indian Institute of Public Health Gandhinagar (IIPHG), NH-147, Palaj Village, opp. New Air Force Station HQ, Gandhinagar, Gujarat 382042, India
[3]Faculty of Medicine, School of Public Health, The University of Queensland, Herston, QLD 4006, Australia

*Corresponding author. Department of HRM and Management, Peter Faber Business School, Building 532—Tenison Woods House, 8-20 Napier Street, North Sydney, NSW 2060, Australia. E-mail: Bhaskar.Purohit@acu.edu.au

Accepted on 23 August 2024

Abstract

The deployment of the health workforce, carried out through initial and subsequent posting and transfer (PT), is a key element of health workforce management. However, the focus of the currently available PT literature is mostly on subsequent PT, and the distinction between initial and subsequent PT has received little research attention. Drawing on this gap, in this paper, we examine how doctors experience their subsequent PT compared with their initial postings in two states in India. The distinctions have been drawn using the prism of six norms that we developed as evidence for implied policy in the absence of documented policy. This mixed-methods study used in-depth interviews of doctors and key informants, with job histories providing quantitative data from their accounts of their PT experience. Based on the interviews of these frontline doctors and other key policy actors, this paper brings to light key differences between initial and subsequent postings as perceived by the doctors: compared with initial postings, where the State demands to meet service needs dominated, in subsequent postings, doctors exercised greater agency in determining outcomes, with native place a central preoccupation in their choices. Our analysis provides a nuanced understanding of PT environment through this shift in doctors' perceptions of their own position and power within the system, with a significant change in the behaviour of doctors in subsequent PT compared with their initial postings. The paper brings to light the changing behaviour of doctors with subsequent PT, providing a deeper understanding of PT environment, expanding the notion of PT beyond the simple dichotomy between service needs and doctors' requests.

Keywords: Undocumented policy, posting, transfer, health workforce, doctors, agency, norms, India, initial posting, subsequent postings, transfer

Key messages

- With subsequent postings, there is a significant shift in doctors' perceptions of their own position and power and a notable change in the doctors' behaviour.
- Doctors' changing behaviour is primarily motivated by their own preferences for native postings—from passive acceptance for initial postings to becoming more active in seeking agency for the subsequent postings.
- PT is a complex phenomenon that goes beyond the simple dichotomies of service needs and requests and beyond the policy vs the implementation dichotomy.

Introduction

Posting and transfer (PT) is a routine management and governance function critical to the delivery of public services because it affects the attainment of health goals through addressing issues of maldistribution, absenteeism, poor morale, reduced productivity and lowered health system accountability (Kwamie *et al.*, 2017). PT is a mechanism to ensure adequate and equitable staffing across services and locations (Purohit *et al.*, 2016). It involves practices that enable the geographic deployment and transfer of frontline health workers and administrators within public health facilities (Sheikh *et al.*, 2015; Heerdegen *et al.*, 2019). We argue that implicit within this are two distinct steps in health workforce deployment: (1) the initial posting—carried out through the recruitment and the placement of health workers to their first post and (2) subsequent PT—which refers to the internal movement of the health workforce from one posting to another, with implications for 'promotion, demotion, and managing service needs and staff shortages toward achieving appropriate utilization of existing human health resources' (Garimella and Sheikh, 2016). Although initial and subsequent postings are distinct processes and there are differences between initial and subsequent postings, the existing research literature does not examine these two functions of PT as dis-

tinct processes. In a previous analysis (Purohit and Hill, 2023), we examined initial postings in two Indian states, identifying six norms constructed from the analysis for first postings (Box 1). These norms were shown to have sufficient validity to enable them to function in the absence of documented PT policy. This paper uses the prism of those norms to focus on subsequent PT, examining the differences between the first and subsequent PT.

There is considerable research on PT conducted in India and other low- and middle-income countries (LMICs); however, most of this literature does not discriminate between first and subsequent PT. The main themes from the available PT literature revolve around issues of corruption, patronage, power dynamics, informalities and the narrow partisan reasons that sometimes determine PT (Collins *et al*., 2000; Iyer and Mani, 2012; Sheikh *et al*., 2015; Purohit *et al*., 2016; Cyan and Pasha, 2017). The literature from India and other LMICs reports PT practices that are incompatible with professional ethics in the context of civil servant and healthcare worker rights and responsibilities (Schaaf and Freedman, 2015). These include policy actors bypassing the formal rules; corrupt practices in form of bribes and use of informal payments by health workers and other civil servants to be appointed to a desirable location; individual actions from the employees to influence their postings; the use of politicians, political parties or high-level government officials to access desirable locations or to avoid undesirable postings; poor implementation of PT rules; opacity in the ways PT is carried out; too frequent transfers; and extended postings experienced by health workers and administrators (Collins *et al*., 2000; Blunt *et al*., 2012; La Forgia *et al*., 2015; Schaaf and Freedman, 2015; Garimella and Sheikh, 2016; Purohit *et al*., 2016; Abimbola *et al*., 2017; Kwamie *et al*., 2017; Heerdegen *et al*., 2019; Mangwi Ayiasi *et al*., 2019).

However, there is very limited research on initial postings, and the differences between initial and subsequent PT. We identified two studies that particularly focused on aspects of initial postings such as duration, determinants and locations of the initial posting, both from Indian health workforce settings. These studies reported perceived inconsistencies in how initial PT is carried out: on most occasions, the postings did not meet health workers' expectations and were perceived arbitrary by the health workers (Purohit and Martineau, 2016a; Purohit and Hill, 2023). Thus, although initial and subsequent PT are distinct deployment functions in the way they operate and are experienced by health workers, there is limited research that differentiates between the two functions within the same context and research settings.

The context of this exploration is a larger qualitative study carried out in India to examine public sector doctors' experiences with the deployment systems from two Indian states. In our earlier paper on initial postings of frontline public sector doctors in two rural Indian states, we addressed the absence of documented policy by constructing norms from the qualitative data (Box 1) and using these as evidence for implied policy (Purohit and Hill, 2023). The data on initial postings showed that these norms are effective in shaping the behaviour of health workers: that service need is accepted as a priority, and thus most postings are unilaterally determined by the administration; that requests from the doctors are considered, but infrequently guarantee a preferred posting; and that other norms that protect doctors' interest based on gender and duration of postings are less consistently implemented (Purohit and Hill, 2023). This paper examines the experiences of subsequent PT of doctors through the prism of these six norms.

Box 1: Norms and their estimated validity for first posting

This box presents the six norms and their face and criteria validity as reported in Purohit and Hill (2023). Face validity is a measure of recognition of norms by study participants; criteria validity measures the consistency with which norms applied against the actual reporting (higher consistency between the two suggesting higher criteria validity and *vice versa*).

Norm 1 (Service Need): Postings are based on locations where the doctors are most needed as determined by state health department (administrators). These are mainly at rural health centres. (High face and criteria validity)

Norm 2 (Native Place): Where possible, doctors should be appointed to their native district. (Moderate face and criteria validity)

Norm 3 (Request Based): Doctors are entitled to request a specific posting, justifying their reasons for consideration by the authorities. (High face and low criteria validity)

Norm 4 (Gender Based): The norm seeks to provide some protection to female doctors, with two strategies expressed: (1) appointment with their spouse in the same district (Norm 4a) and (2) avoiding remote postings for female doctors (Norm 4b). (Low face validity and low criteria validity)

Norm 5 (Minimum Duration): Minimum duration for postings should be for at least 36 months so that doctors spend sufficient time settling into a post, allowing them to build rapport with the community they serve. (Low face validity and low criteria validity)

Norm 6 (Maximum Duration): Postings should not exceed 5 years (60 months) assuming compliance with Norm 5 (.Low face validity and low criteria validity)

Methods

This mixed-methods study, primarily qualitative in nature, examined the experiences of doctors in subsequent PT, using the six norms (Box 1) constructed from the analysis detailed in their discussion of their initial posting (Purohit and Hill, 2023). Mixed-methods research, using the qualitative and job histories methods, is a useful way to the inquiry into health workers' perspectives and viewpoints (Witter et al., 2017). This paper primarily examines doctors' perspectives and experiences of PT, rather than seeking to provide a more comprehensively and objective institutional and systems analysis.

Study setting

This study was carried out between February 2018 and October 2018 in two Indian states, one located in North-East part of India and the other in North-West India. For the paper, state names have been anonymized and referred as States A and B, respectively. The states were purposively chosen for

Table 1. Work-related characteristics of doctors ($n = 33$)

	State A ($n = 15$)	State B ($n = 18$)
Sex		
Male	8	16
Female	7	2
Age (years)		
Mean (range)	35.11 (27–48)	40.18 (27–51)
Total service (in months)		
Mean (range)	104 (8–264)	142.53 (12–396)
Work at current place in months		
Mean (range)	38.53 (4–84)	46.13 (6–108)
Current place of work		
PHC	8	10
CHC	4	7
SDH/DH	3	1

Table 2. Key informants interviewed ($n = 28$)

Stakeholder	State A (number interviewed) $n = 16$	State B (number interviewed) $n = 12$
State-level bureaucrats	1	2
State-level health administrators	2	2
District-level health administrators (DoH)	3	2
Senior administrative officers (NHM)	1	2
Administrative from the AYUSH department	2	1
Doctor's association members	2	2
Public Service Commission representative	1	–
Other stakeholders	4	1
Total	16	12

the strong contrast presented in each state, with the maximum divergence in terms of geography, demographics, heath indicators and health workforce availability.

State A is one of the smallest states in India by geographic area, located in North-East India, with a very small population and above average literacy rate when compared with national average of 73.14. Being a small state, the state does not have a huge public health infrastructure with just four district hospitals (DHs); two community health centres (CHCs) and 24 primary health centres (PHCs). In contrast to State A, State B is located in the north-western part of India and is one of the largest states by geographic area. The literacy rate in the state is lower compared with the national average of 73.14%. However, being a large state, it has 8 government medical colleges, 34 DHs, 12 sub-district hospitals (SDHs), 588 CHCs, 2078 PHCs and 14 405 SCs (Government of India, 2018).

Selection of participants, data collection and sample size

We developed a semi-structured questionnaire to explore frontline public sector doctors' experiences with the PT practices, with a focus on the location and duration of postings, doctors' experience of their PT and the perception of reasons behind the PT decisions. Utilizing purposive sampling using maximum variation, we included 15 doctors from State A and 18 from State B to examine their experiences of the subsequent PT (Table 1). As A is a small state, we had representation of doctors from all four districts in this state. However, for B, we used purposive sampling to interview 18 doctors representing six districts who were purposively selected to ensure the selection of doctors from districts that were close to and remote from state headquarters. Most doctors were selected purposively using convenience sampling based on their availability at the health facilities, with most doctors working in rural health centres, and also some representation of doctors from urban health centres. The purposive sampling ensured the inclusion of doctors with a wide range of work experience with the health department.

Additionally, we used a simple job history format to collect information on various job-related events of doctors such as key dates, durations and locations for PT. The quantitative data were extracted from the job histories of the 33 doctors from the two states. Two previous research studies related to the health workforce from India have used mixed methods, including job histories using qualitative methods (Kadam *et al.*, 2016; Purohit and Martineau, 2016b).

In addition to the doctors, we also interviewed 28 health administrators and other policy actors to understand the existing policies, PT systems and their viewpoints in managing the PT of doctors. The study included 16 health administrators and other policy actors from State A and 12 from State B, purposively included for their experience on the existing policies and research topic, and for the positions they held in various organizations, institutions and government departments. The purposive sampling ensured a wide representation of policy actors (Table 2).

The lead author carried out the data collection. In total, 58 interviews were recorded while detailed notes were taken for the three unrecorded interviews. Twenty-three interviews (from State B) were conducted in a mix of English and Hindi (official language in India), while the remaining 38 interviews were conducted in English. Interviews with participants were conducted at their offices, with the exception of six interviews with doctors conducted at a training centre, and one interview with a key informant conducted at his residence. The interview transcripts and detailed notes for all the 61 interviews were imported into NVivo 12 for analysis.

Data analysis and ethics

We used Framework Approach, a matrix-based thematic analysis, to arrange and synthesize qualitative data based on the themes generated from the data (Ritchie and Lewis, 2003). For the analysis of the data, we used the main themes identified in our previous thematic analysis—Service Needs, Native Place, Request Based, Gendered Considerations and Minimum and Maximum Duration (Purohit and Hill, 2023), with coding of data related to subsequent PT identifying additional emergent themes.

We then used the qualitative and quantitative data extracted from the job histories to compare the experience of doctors in subsequent PT against the six norms and their recollection of their initial postings. The quantitative data from job histories provided evidence of conformity with or divergence in subsequent postings from the norms that were constructed from their reports of their initial postings. In the

Table 3. All postings compared with Norms 1 (Service Needs), 2 (Native Place), 3 (Requests) and other actions

Postings	State A: transfers based on Norms 1, 2 and 3 and other actions by doctors ($N = 15$)			State B: transfers based on Norms 1, 2 and 3 and other actions by doctors ($N = 18$)				Total
	Norm 1: Service Need	Norm 3: Request Based	Total State A	Norm 1: Service Need	Norm 3: Request Based	Other actions	Total State B	States A and B
First posting	15 (9)	–	15 (9)	14 (3)	4 (4)		18 (7)	33 (16)
Second posting	2	8 (4)	10 (4)	10 (2)	2 (1)	1(1)	13 (4)	23 (8)
Third posting	3 (1)	2 (1)	5 (2)	1 (1)	5 (3)	4 (4)	10 (8)	15 (10)
Fourth posting	2	2 (1)	4 (1)	7 (3)	–	–	7 (3)	11 (4)
Fifth posting	3 (2)	1(1)	4 (3)	3 (2)	–	2 (2)	5 (4)	9 (7)
Sixth posting	1	–	1	3 (2)		1(1)	4 (3)	5 (3)
Seventh posting				2(2)	1(1)	–	3 (3)	3 (3)
Eighth posting				1 (1)	–	–	1 (1)	1 (1)
Ninth posting				–	–	1(1)	1 (1)	1 (1)
Tenth posting				–	–	1(1)	1 (1)	1 (1)
Total postings (native postings)	26 (12)	13 (7)	39 (19)	41 (16)	12 (9)	10 (10)	63 (35)	102 (54)

Numbers in brackets reflect the actual number posted at their native places.

absence of access to state employment records, qualitative data from interviews with KIs was triangulated against the quantitative findings from job histories, providing support for the doctors' perspectives.

Ethical approval was received from the Human Research and Ethics Committee and Institutional Ethics Committee (IEC) at the authors' institutes with approval numbers '2017001666/TRC-IEC' and 'TRC-IEC No. 9/16'. Informed written consent was sought from all the participants before data collection, and the study participants were assured of confidentiality during all times. Specific consent to record interviews was obtained from all. Three participants consented to interview but not to voice recording. The personal data and transcripts were anonymized prior to analysis.

Findings

We analysed the qualitative data and the job histories to understand doctors' experiences of the subsequent PT systems through the prism of the six norms established from reports of their initial postings (Purohit and Hill, 2023). The job history data suggest that at the time of interviews, a total of 102 postings and 69 subsequent postings were experienced by the 33 doctors. Tables 3 and 4 show the distribution of the postings held by the 33 doctors (including nine female doctors) analysed in terms of Norm 1 (Service Needs), Norm 2 (Native Place, defined as the town or a city where the doctors are from. This mainly includes the place they were born and lived while young, and where their parents reside) and Norm 3 (Request Based). Table 5 compares the duration of all postings with the expectations of Norm 5, Minimum Duration, and Norm 6, Maximum Duration. Compared with initial postings, these analyses showed substantial changes in the patterns of compliance with the norms, with qualitative data providing some explanatory basis for these differences. The main patterns identified include:

(1) Service Needs defined by the state lose dominance as the determining factor for subsequent PT.
(2) Doctors' request was increasingly reported as the basis for subsequent PT.
(3) Native place is a strong driver for doctors' requests.
(4) In State B, 'Other actions' emerges as a basis for subsequent PT.
(5) Prioritization of female PT based on gendered considerations.
(6) Duration guidelines are inconsistently applied.

Service needs defined by the state lose dominance as the determining factor for subsequent PT

While service needs defined by the state dominated the rationale for initial postings, its role was substantially reduced in the reported justification for subsequent PT. Norm 1 (Service Needs) explained only slightly over than half of the subsequent postings (38/69), compared with the substantially higher 88% (29/33) for first postings. This deviation is observed from second postings onwards and is offset in part by the rise of postings based on requests from doctors.

Doctors' request was increasingly reported as the basis for subsequent PT

An increased percentage of doctors' requests were recorded in subsequent postings, 31% (21/69), compared with only 12% (4/33) for first postings. Study respondents indicated that the reasons considered a valid basis for a doctor's request for transfers included postings at native locations; doctors having already served in a rural location; caring for sick family members; and posting with the spouse. Mutual transfers where two doctors agree to exchange positions would also be considered on request. Approval for all such requests remained subject to the availability of vacancies, and the state's discretion.

> "*They* [health department] *do consider doctors' family issues, personal issues when request for transfer is made but there should be a vacancy*" (State B, Doctor 05)

Table 4. Norm 4, gender compared with other norms

Number of postings and native place postings: Norm 2, for female participants	State A: transfers based on Norms 1, 2 and 3 and other actions by female participants (N= 7)			State B: transfers based on Norms 1, 2 and 3 and other actions by female participants (N = 2)				Total States A and B
	Norm 1: Service Need	Norm 3: Request Based	Total	Norm 1: Service Need	Norm 3: Request Based	Other actions	Total	
First posting		-						
Urban location	1	1	2					2
Rural	5 (2)		5 (2)	2 (1)			2 (1)	7 (3)
Second posting								
Urban						(1)	(1)	(1)
Rural		3 (2)	3 (2)					3 (2)
Total	6 (2)	4 (2)	10 (4)	2 (1)		(1)	3 (2)	13 (6)

Figures in brackets reflect the actual number posted at their native places.

Table 5. Length of postings held compared with Norms 5 and 6 on Minimum and Maximum durations

	Duration of postings held in months (n = 33)							
	Up to 36 months			36–60 months (as per Norm 5)		Over 60 months		Total
	Up to 12	≥12 to 24	25–36	≥36 to 48	48–60	≥60 to 72	≥72+	
	First posting							
State A	3 (1)	3 [3]	2 (2) [1]	*1*	2 [2]	3 (2) [2]	1[a]	15 (5) [8]
State B	6 [3]	3 (1)	2[1]	3 (2) [2]	*2*	1	(1) [1][a]	18 (4) [7]
Total	9 (1)[3]	6 (1) [3]	4 (2) [2]	4 (2) [2]	4 [2]	4 (2) [2]	2 (1) [1]	33 (9) [15]
	Second posting							
State A	2 (1) [1]	(1)	1	3 (2) [1]	2 [1]		1 [1][a]	10 (4) [4]
State B	2	7 [3]	2 (1) [1]		1 (1) [1]		1	13 (2) [5]
Total	4 (1) [1]	8 (1) [3]	3 (1) [1]	3 (2) [1]	3 (1) [2]		2 [1]	23 (6) [9]
	Third posting							
State A	3[2]	1	1					5 [2]
State B	2 (1) [2]	3 [2]	3 [2]	(2) [2]				10 (3) [8]
Total	5 (1) [4]	4 [2]	4 [2]	*2* (2) [2]				15 (3) [10]
	Forth posting							
State A	1	1		(1)	1 [1]		1	5 (1) [1]
State B	3 (1) [2]			2 [1]			2[1]	7
Total	4	1		3	1		3	12
	Fifth posting							
State A	1 (1) [1]	1		1(1) [1]		1 (1) [1]		4 (3) [3]
State B	2 [2]		1 [1]				2 (2)	5 (2) [3]
Total	3 (1) [3]	1	1[1]	1 (1) [1]		1 (1) [1]	2 (2)	9 (5) [6]
	Sixth posting							
State A							1 (1)	1 (1)
State B		2 [2]		2(1) [2]				4 (1) [4]
Total		2 [2]		2 (1) [2]			1 (1)	5 (2) [4]
	Seventh posting							
State B		1 [1]		1 (1) [1]			1 (1) [1]	3 (2) [3]
Total		1 [1]		1 (1) [1]			1 (1) [1]	3 (2) [3]
	Eighth posting							
State B		1 [1]						1 [1]
Total		1 [1]						1 [1]
	Ninth posting							
State B			1					1
Total			1					1
	Tenth posting							
State B			1 (1) [1]					1 (1) [1]
Total			1(1) [1]					1(1) [1]
Total	25	23	14	*16*	*8*	*5*	11	102

Figures in brackets reflect the actual number continuing at the time of interview.
State A—none of the respondents experienced more than six transfers.
Four doctors who refused to join have been counted ~ months.
None of the doctors from State A experienced more than six postings.
Square brackets indicate native place postings.
[a]Female doctor.

> *"We can only transfer a doctor on request if there is a vacancy"* (State A, KI 03: District office: Health department)

Despite the increase in the proportion of postings based on doctors' requests, however, a few doctors undergoing subsequent PT reported that their requests were denied, sometimes on more than one occasion.

> *"In my job I have made many requests for transfer, but my requests have never been accepted."* (State B, Doctor 10)

Native place is a strong driver for doctors' requests

There was a small rise in subsequent postings at native locations with 55% of postings (38/69) compared with 48% (16/33) of initial postings at native locations. In the initial postings, although there were only four formal requests, all the request-based postings at native locations were granted. In subsequent postings overall, 57% (12/21) of doctors' requests for native locations were granted. Even where subsequent postings were reported as being based on service needs, without doctors specifically requesting, 42% (16/38) of postings were made at their native place postings. This is similar to the proportion of appointments at native place without specific request noted for the initial postings (12/29), suggesting that administrators actively take native place into consideration. However, KIs suggested that posting doctors at their native places was not always possible and that vacancy was a key determinant.

> *"My transfer was based on a simple request, and it was granted because not many doctors want to serve where I was transferred"* (State A, Doctor 03)

> *"When I went up to my higher authorities to request transfer at my hometown, they told me like that there is no vacancy right now, so you we cannot transfer you. However, a week later, the doctor who worked there was transferred elsewhere, and I got my transfer there."*(State A, Doctor 12)

> *"We have a scarcity of doctors, and we need to fill up the vacant places and sometimes it is not possible to do postings in native places… because doctors are reluctant to go to remote areas, we cannot post everyone in native places"*(State A KI 06: District office: Health department)

Native locations were a strong driver for doctors' requests for subsequent postings with more than half of the request-based postings (12/21) made for postings at the native locations of doctors. We also noted that with subsequent PT, doctors not only became more active in their requests but were also more willing to exercise agency if their requests, especially for native places, were denied. This was identified in the emergence of other bases for subsequent PT.

In State B, other actions emerge as a basis for subsequent PT

Norm 1 (Service Needs) and Norm 3 (Doctors' Requests) were identified as the main determinants for first postings. In subsequent postings in State B, however, there was an emergence of other actions not explained by either of these two bases for PT. These other actions were reported only in State B but marked a perceptible shift in doctors' agency to influence PT, from passive acceptance evident in initial postings to becoming more active in subsequent postings. From the second posting onwards, these actions included direct and indirect activities intended to influence their subsequent postings. Ten subsequent postings were reported by doctors to have been influenced by other actions, including:

Direct action: Resistance or refusal for posting. Doctors' refusal to accept State-decided postings was reported for four postings, all of which were at remote locations. Three of these postings were to non-native locations.

> *"The new posting was not suitable for me, so I refused to join"*(State B, doctor 06)

> *"I did not want to join this posting* [referring to the place of posting decided by the health department], *so first I refused and then applied for extension"* (State B, Female Doctor 01)

Indirect action: Use of personal connections. Doctors reported that they used personal contacts as a means to influence their postings.

> *"If you know the right and powerful people in the system, then you can get your choice of posting"*(State A, Doctor 04)

> *"Yes, so I had to use my own contacts to get posting at my hometown"*(State B, Doctor 10)

> *"Doctors sometimes pressurize us by getting support from their local political representatives to get postings at their choice of locations"*(State B, KI 02: State office: Health Department)

Combined direct and indirect action: In order to secure desirable postings, doctors indicated that more than one approach may be necessary. The below quote explains how one doctor combined both forms of action:

> *"So first I refused and then applied for extension. And somehow, I got one month time and during this time period, my father knew someone influential and got me transferred here"*(State B, Female Doctor 01)

Based on the job histories and qualitative data, posting at a native place appears to be a central preoccupation leading to indirect action—8 of 10 postings based on indirect actions were carried out to secure native locations. In the remaining two cases, two doctors had been denied their right to a native place posting, and reallocated to distant health centres as a result of indirect action used by other doctors to secure their own postings at their native locations.

> *"If you have very good connections with the minister or the bureaucrats then transfer is easily possible, however some other doctors might become the victim of that connection"*(State A, Doctor 04)

> *"I was transferred to this health centre* [away from native district] *just because someone else wanted to join here, so I was thrown from this place"*(State B, Doctor 12)

Prior unsuccessful requests for native location postings resulted in pre-emptive interventions through indirect action to guarantee subsequent postings to their native locations.

> *"In my job I have made many requests for transfer, but my requests have never been accepted… Yes, so I had to use my own contacts to get posting at my hometown"*(State B, Doctor 10)

> *"I made a request for posting which was not accepted so I used my own ways to get posting at my native place. I can tell you that if you don't have any approach, they you have to go wherever you are posted by the government"*(State B, doctor 06)

Prioritization of female PT based on gendered considerations

The data on subsequent postings for female doctors are limited to only four female participants, each of whom reported on two postings. Of the four subsequent postings, three were based on doctors' requests—two granting PT to native locations and one at non-native location, suggesting that the administration does attempt to approve women's requests and grant native postings. The remaining one was secured at native location by using indirect action. The data also suggest that native place postings were the main basis of requests by the female doctors.

> *"I requested a transfer to my hometown primary health centre* [in rural setting] *due to some personal reasons. As it is not a health centre that many doctors really like to serve, and also because my chief medical officer was very supportive, so my request for transfer was accepted. Also I am happy with my posting as I have gathered enough knowledge and skills in health program management and I am happy to work at grassroot level"*(State A, Doctor 04)

> *"I did not want to join the place where I was initially posted… Somehow, I got one month time and, in that period, my father got me transferred here"*(State B, Doctor 17)

Duration guidelines are inconsistently applied

We observed major inconsistencies in the perceived application of Norm 5 (Minimum Duration) for the subsequent postings with nearly two-thirds (43/69) of the postings held for <36 months. The observed trend in the job history data is suggestive of high churn in the early postings—with disruptive shorter appointments beginning with the first posting and continuing up to fifth posting.

Some of the doctors who were posted at non-native locations considered the shorter appointments unfavourable and reported using formal requests to get postings to their native locations. In other instances, however, a few doctors reported the use of indirect action to move to native locations.

> *"When I was posted at PHC, yet again, I was told that it is just a temporary posting for three to six months, but it has already been 3 years. I have made several requests for transfer, but nothing has happened"* (State A, Doctor 06)

> *My previous posting was at a health centre located in xxx district* [referring to non-native district] *and I was posted there for about 2 years. Then later, I used my approach to get posting at my native place.*(State B, Doctor 08)

Although native place postings were important for the doctors, we observed an outlier who refused a posting offered at his native place to express his discontent with being frequently transferred in the job.

> *"I was moved yet again to another location within a year. I have been very unhappy with my transfers because I have already been transferred three-four times in the last few years … and I have no stability"*(State B, Doctor 16)

Norm 6 (Maximum Duration) was also perceived to be inconsistently applied for the subsequent postings with 10 postings held over 60 months and 9 of these held for over 72 months.

Extended postings in native places appeared convenient and were described as offering some stability in the case of three doctors who served in their native places for over 60 months. For instance, in the case of one doctor, the longest duration of native place posting was held for 132 months, based on the doctors' request at an urban health centre:

> *"My latest transfer was at a Community Health Centre in my native district which is located very close to my residence. I have been working here for over seven years and I am happy"*(State B, Doctor 12)

However, some doctors posted at non-native locations considered the extended postings disruptive—prompting them to use indirect action to influence their PT.

> *"I was at a post for more than six years, but the posting was too far from my residence and was at a rural location. I couldn't give time to family and to my old parents who required some attention and care. Then there were problems with the residential facilities as it was a very rural and tribal area… So, I had to use my contacts….so it worked for me"*(State B, Doctor 12)

Although native place postings were important considerations for doctors, we observed outliers with a few doctors who were indifferent to the extended postings, even if these were at non-native native locations.

> *"I have been posted here for more than six years; this is not my home district but it's fine. This posting was decided by the state"*(State B, Doctor 15)

Discussion

This study suggests that while the elements that contribute to PT decisions remain constant for frontline doctors in Indian States at each successive posting, the power dynamics change perceptibly from initial PT to subsequent postings. Documenting these changes allows us to differentiate between initial and

subsequent postings, and provides important insight into doctors' own perception of their agency in PT once they have secured an appointment within the rural health service.

The most substantial change is to the dominance of service needs as the primary determinant for outcomes of the PT decision-making process. Accepted by both the bureaucracy and employed doctors as a legitimate criterion for PT in initial posting, the primacy of service needs drops in subsequent postings as doctors' perceptions of their own agency increases: the exercise of their right to request a post increases, with documented success; gendered based considerations appear to be respected for female doctors, and appointment to native place—an apparent priority for doctors—is honoured in most cases.

Several other PT-related studies from India have also reported service needs (commonly referred as 'public interest') as a main reason for PT (De Zwart, 2000; Banik, 2001; Garimella and Sheikh, 2016; Purohit *et al.*, 2016). In our study, service needs as determined by the state health department are based on strategic deployment of doctors where they are most needed, and the availability of vacancies is implicit within this norm. Studies from other LMICs have also reported that the rationale for initiating transfers of health workers is based on equal distribution of staff and skills mix according to health workforce requirements, but also depends upon the availability of vacancies (Heerdegen *et al.*, 2019). However, the existing PT literature does not compare service needs as a determinant for subsequent PT but instead compares it to its perceived role in initial postings. Our paper suggests a transition from unilateral decision-making by the state in initial postings to meet its service needs to a more negotiated—and sometimes challenged—process for subsequent postings where the administration provides more concessions for doctors' considerations and requests.

Our study also reports increasing number of requests made and granted for subsequent postings, though the four requests made in initial postings seem all to have been honoured. While the legitimacy and availability of the request process is broadly recognized, doctors concede that such requests may not always be approved for reasons such as unavailability of vacancies or doctors not having served sufficient time at current post. PT-related literature from India (Zwart, 1994; Banik, 2001; Iyer and Mani, 2012; Purohit *et al.*, 2016) and several other LMICs, such as Ghana and Nigeria, also reports that PT can be based on health workers' requests and such requests may not always be granted for reasons related to insufficient time spent at the current post and unavailability of vacancies at the requested facilities (Abimbola *et al.*, 2017; Kwamie *et al.*, 2017; Heerdegen *et al.*, 2019). However, it is the increasing resort to overt request in subsequent postings that is apparent in our study and suggests a willingness by doctors to apply leverage to ensure that the request is granted. Our study shows that an increasing number of requests are made and granted in subsequent PT, and it also speaks about a significant change in doctors' behaviour following the denial of their PT requests.

One exceptional finding from our study is the strong attachment doctors place to native postings and the extent to which they can go to secure these. Evidence from the literature suggests that civil servants belonging to administrative cadre in India strongly prefer postings that are in close proximity to home, and urban postings over rural (Iyer and Mani, 2012). From a governance and health workforce perspective, while there may be benefits to placing doctors at their native places, native place postings cannot be consistently provided for all health workers. While a preference for native place postings was clear, other issues of professional development and career progression may be in tension with this. One Indian study reports a high preference placed on urban postings over native postings. The same study also reports that despite health workers' rural upbringing or with homes in the rural areas, they may not wish to work at their native locations (Nallala *et al.*, 2015). Poor work environment, lack of minimum residence facilities and political interference have been cited as some of the reasons for doctors' lack of willingness and poor motivation to work in rural Pakistan (Shah *et al.*, 2016) and higher rate of absenteeism among doctors posted to remote facilities in India (Muralidharan *et al.*, 2011).

In contrast to our findings of evidence of preference for postings at native locations, supported by both doctors and bureaucrats, the issue of native place postings is conflicted. Some state PT regulations from India suggest that civil servants must not be posted at their native places (Government of Gujarat, 2005). However, a PT study from the same state in India suggests that due to critical health worker shortages, the rule for proscribing postings at native locations did not strictly apply to doctors, and several doctors have been posted at their native locations (Purohit and Martineau, 2016a). Iyer and Mani (2012), in their PT study, report that posting civil servants in India to their home states has two main advantages: home state officers are familiar with their local language and culture, which might enable them to acquire expertise faster, and they are also more likely to be familiar with local power and patronage networks, which might make it easier for them to develop loyalty links with state politicians (Iyer and Mani, 2012). Conversely, Weiner (1989), in his study conducted in Nepal, reported how certain doctors in the system occupy a privileged position by maintaining the traditional kinship on patron–client system of promotions and placements (Weiner, 1989).

Another notable difference observed between subsequent PT and the initial postings is the extent to which doctors will take action to secure native postings. In PT, the juxtaposition of service needs and doctors' preferences for native location postings plays out differently depending on whether there is congruence between priority for postings based on service needs and doctors' preference for native locations, or discordance between the two. When the two are in congruence, there appears to be some concession by administration in posting the doctors to native places and no deviations in doctors' behaviours are observed. The practice of native location postings suggests consideration towards employees needs and in line with World Health Organizations' (WHO) recommendations for improved retention (World Health Organization, 2010). The importance of native location-based health workforce management practices are also underscored by formalization of admission policies for medical students in Bangladesh that emphasize selection based on native location (Rawal *et al.*, 2015).

However, evidence generated from this paper also suggests tensions between the service needs that seem to prioritize strategic postings, and doctors' preference for native locations. These tensions between priority and expectations of

the two parties become particularly evident for subsequent PT—doctor's perceptions of their own position and power within the system changes. The shift in power balance is observed through a notable change in the behaviour of doctors by using a combination of tactical actions (direct and indirect) to successfully negotiate subsequent PT at native locations—a phenomenon not observed for the initial postings. Therefore, as opposed to first postings, where placement at urgent locations is the priority, doctors seem to passively accept this in initial postings. However, once doctors have been initially posted at the first posting location, in subsequent postings, doctors see their own needs as more critical. Since postings become increasingly strategic in terms of doctors' personal needs and professional opportunities, doctors are willing to exercise agency to influence their PT at native places.

Participants from State B openly discussed personal instances of use of tactical actions, particularly use of political influence to affect their PT, though there was only one very generic reference to the use of political influence from State A. This may be attributed to the difference in contexts, especially considering the smaller geography and small number of doctors from State A. Considering the embeddedness of political influence in civil services, throughout India, and the sensitive nature of the topic under investigation, this does not preclude the possibility of involvement of doctors in indirect actions from State A.

Our research also provides evidence of the strong assertions made by doctors in directly refusing to join postings as well as how some doctors combine direct and indirect action to dismiss undesirable postings and to secure desirable postings. To our knowledge, no other studies in the area of PT of health workers report direct refusals and combination of this with the indirect actions to influence PT. Thus, our research findings are novel and suggest the increasing power and negotiation space doctors have for subsequent PT in contrast to the initial postings.

Our analysis provides insights into the changing dynamics of the PT ecosystem for subsequent PT compared with the initial postings, thus contributing to the Health Systems and Policy Research (HSPR) literature in several ways. First, this is the first study to suggest a significant shift in doctor's perceptions of their own position and power within the system, as they progress and navigate through to the subsequent postings compared with the initial postings. Second, it brings to light the complex interplay of tensions between service needs and doctors' own expectations for subsequent postings. Lastly, the paper highlights a significant change in behaviour of doctors from passive acceptance for initial postings to the assertion of agency for subsequent PT, primarily motivated by their own preferences for native postings. Our study provides evidence of the changing context with subsequent PT compared with the initial posting where maintaining a balance between administrations' and doctors' needs becomes increasing challenging and leads to power imbalances. While the departmental needs may take precedence over individual needs (Purohit and Martineau, 2016a), nonetheless, some doctors are increasingly able to successfully counterbalance this in their subsequent postings.

There are few limitations of the study relating to access to study participants and constraints of sampling. One, the job history data used to construct Norm 3 (Request Based) recorded situations where respondents specifically volunteered that they had made a request that was granted or not granted. Although some doctors indicated that their requests were not granted, we do not have the exact count of respondents who indicated if their request for subsequent postings was denied. Two, we had limited data to explore perceived implementation of the Norm 4 (Gender Based) and compare it to the first postings—only nine female doctors participated in the study and only four of them experienced two postings. Thus, we cannot conclude whether Norm 4 (Gender Based) fails to safeguard female participants against rural postings. Three, as far as duration of postings is concerned, it is difficult to comment on trends beyond the fifth postings as the meaning of the numbers is increasingly tenuous because of the sampling and the diminishing numbers in each round of postings. Considering the research limitations and some of the unexamined issues flagged in our research, qualitative research, grounded in social science, will be useful to explicate the complex political, power and organizational dynamics at play in PT (Sheikh *et al.*, 2015).

In conclusion, this paper provides insights into changing behaviour of doctors with subsequent PT while providing a deeper understanding of PT environment. The paper expands the notion of PT beyond: (1) the simple dichotomy of service needs and requests on which PT is primarily based; (2) beyond subsequent PT—towards understanding of PT as a whole (initial and subsequent PT) and (3) beyond the simple policy and implementation dichotomy. There is a greater need for understanding PT beyond these simple dichotomies at multi-dimensional levels and considering the changing dynamics of PT with subsequent PT.

LMIC/HIC authorship

The first author B.P. is from LMIC and carried out the data collection in India during 2018 and 2019 while being affiliated with the IIPHG (Address: NH-147, Palaj Village, opp. New Air Force Station HQ, Gandhinagar, Gujarat 382042, India). The author is currently affiliated with the Australian Catholic University.

Funding

We acknowledge the Public Health Research Institute (PHRI) and the Department of Science and Technology (DST) for funding the research and IIPHG and PHFI for administering the funding.

Acknowledgements

The authors specially acknowledge the state health departments and the study respondents.

Author contributions

B.P. and P.H. conceived and designed the study. B.P. collected the data and carried out the initial analysis. P.H. provided significant inputs for data analysis. B.P. and P.H. drafted the manuscript, and P.H. provided critical revision of the article. All authors approved the final version of the paper.

Reflexivity statement

The authors include an early career researcher (PhD candidate at the time of data collection for the research) and a senior academician and researcher. Authors come from LMIC and High Income Country with diverse backgrounds—one from a health management background from India and several years of experience in conducting HSPR from India. The other author is trained in medicine with education in health management and a doctoral degree in Public Health and with extensive health policy and systems experience from Australia and several other LMICs including Cambodia and Vietnam.

Ethical approval. Ethics approval was received from the 'Human Research Ethics Office' at University of Queensland (UQ), approval number 2017001666/TRC-IEC No.: 9/2016, and from the ethics review committee at the Indian Institute of Public Health Gandhinagar (IIPHG), India, approval number TRC-IEC No. 9/16.

Conflict of interest: None declared.

References

Abimbola S, Olanipekun T, Schaaf M *et al*. 2017. Where there is no policy: governing the posting and transfer of primary health care workers in Nigeria. *The International Journal of Health Planning and Management* **32**: 492–508.

Banik D. 2001. The transfer raj: Indian civil servants on the move. *The European Journal of Development Research* **13**: 106–34.

Blunt P, Turner M, Lindroth H. 2012. Patronage's progress in post-soeharto Indonesia. *Public Administration and Development* **32**: 64–81.

Collins CD, Omar M, Hurst K. 2000. Staff transfer and management in the government health sector in Balochistan, Pakistan: problems and context. *Public Administration and Development* **20**: 207–20.

Cyan MR, Pasha O. 2017. A symbiosis of civil service and politics in transfers: the case of Pakistan's management cadres. *Public Administration* **95**: 1077–91.

De Zwart F. 2000. Personnel transfer in Indian state bureaucracy: corruption and anti-corruption. Amsterdam: SISWO.

Garimella S, Sheikh K. 2016. Health worker posting and transfer at primary level in Tamil Nadu: Governance of a complex health system function. *Journal of Family Medicine and Primary Care* **5**: 663–71.

Government of Gujarat. 2005. Revised guidelines of appointments and transfers of government employees/ officers. In: DEPARTMENT, G. A. (ed). Gandhinagar: General Administration Department, Government of Gujarat.

Government of India. 2018. Rural health statistics-2018. Government of India.

Heerdegen ACS, Bonenberger M, Aikins M *et al*. 2019. Health worker transfer processes within the public health sector in Ghana: a study of three districts in the Eastern Region. *Human Resources for Health* **17**: 45.

Iyer L, Mani A. 2012. Traveling agents: political change and bureaucratic turnover in India. *Review of Economics and Statistics* **94**: 723–39.

Kadam S, Nallala S, Zodpey S *et al*. 2016. A study of organizational versus individual needs related to recruitment, deployment and promotion of doctors working in the government health system in Odisha state, India. *Human Resources for Health* **14**: 7.

Kwamie A, Asiamah M, Schaaf M, Agyepong IA. 2017. Postings and transfers in the Ghanaian health system: a study of health workforce governance. *International Journal for Equity in Health* **16**: 85.

La Forgia G, Raha S, Shaik S, Maheshwari SK, Ali R. 2015. Parallel systems and human resource management in India's public health services: a view from the front lines. *PAD Public Administration and Development* **35**: 372–89.

Mangwi Ayiasi R, Rutebemberwa E, Martineau T. 2019. "Posting policies don't change because there is peace or war": the staff deployment challenges for two large health employers during and after conflict in Northern Uganda. *Human Resources for Health* **17**: 27.

Muralidharan K, Chaudhury N, Hammer J, Kremer M, Rogers FH. 2011. Is there a doctor in the house? Medical worker absence in India. Washington, DC: World Bank.

Nallala S, Swain S, Das S, Kasam SK, Pati S. 2015. Why medical students do not like to join rural health service? An exploratory study in India. *Journal of Family and Community Medicine* **22**: 111–7.

Purohit B, Hill PS. 2023. Posting and transfer: the experiences of public sector doctors in two Indian states. *Health Policy and Planning* **38**: 1121–30.

Purohit B, Martineau T. 2016a. Initial posting-a critical stage in the employment cycle: lessons from the experience of government doctors in Gujarat, India. *Human Resources for Health* **14**: 41.

Purohit B, Martineau T. 2016b. Issues and challenges in recruitment for government doctors in Gujarat, India. *Human Resources for Health* **14**: 43.

Purohit B, Martineau T, Sheikh K. 2016. Opening the black box of transfer systems in public sector health services in a Western state in India. *BMC Health Services Research* **16**: 419.

Rawal LB, Joarder T, Islam SM, Uddin A, Ahmed SM. 2015. Developing effective policy strategies to retain health workers in rural Bangladesh: a policy analysis. *Human Resources for Health* **13**: 36.

Ritchie J, Lewis J. 2003. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage.

Schaaf M, Freedman LP. 2015. Unmasking the open secret of posting and transfer practices in the health sector. *Health Policy and Planning* **30**: 121–30.

Shah SM, Zaidi S, Ahmed J, Rehman SU. 2016. Motivation and retention of physicians in primary healthcare facilities: a qualitative study from Abbottabad, Pakistan. *International Journal of Health Policy and Management* **5**: 467–75.

Sheikh K, Freedman L, Ghaffar A *et al*. 2015. Posting and transfer: key to fostering trust in government health services. *Human Resources for Health* **13**: 82.

Weiner SJ. 1989. 'Source force' and the Nepal medical profession. *Social Science & Medicine* **29**: 669–75.

Witter S, Namakula J, Alonso-Garbayo A *et al*. 2017. Experiences of using life histories with health workers in post-conflict and crisis settings: methodological reflections. *Health Policy and Planning* **32**: 595–601.

World Health Organization. 2010. Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva: World Health Organization.

Zwart DF. 1994. *The Bureaucratic Merry-Go-Round*. Amsterdam: Amsterdam University Press.