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Original Article

Posting and Transfer: the experiences of public sector doctors in two Indian states

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Abstract

Posting and Transfer (PT) refers to deployment of the health workforce in ways that ensure appropriate numbers and distribution. Although PT is a crucial aspect of health workforce governance, it remains under-researched from the viewpoint of implementation, health workforce and governance. The aim of this paper is to examine public sector doctors' experience of their initial postings, in the context of local policy from two Indian states. We carried out a review search for policy documentation. A total 61 in-depth interviews were conducted in both states with 33 doctors, as subjects of the study. There were 28 key informant (KI) interviews of health administrators and other policy actors to understand their perspectives of PT policies and implementation. Thematic analysis was used to analyse data. Job histories were constructed from the doctors' interviews to track their experience with the PT system, and analysed using location, duration and postings. Despite search for state policy for PT, we were unable to identify any policy documentation. However, participants referred to PT practices that suggested expectations of what the poliy meant to them. These expectations were corroborated by KI, and the job histories and interview data enabled the authors to construct a series of norms, interpreted as evidence of implied policy. The main norms identified relate to service need, native place, request, gender and posting duration. The norm related to state need had strong face validity, while other norms based on request, gender and duration were less consistent in application. In the absence of documented policies, the construction of norms from the qualitative data proved useful to examine the dynamics of health workers' interactions with the initial PT systems This construction of norms provides a methodological innovation allowing health policy and systems researchers to compensate for the absence of documented policy in exploring PT functions.

Keywords: Undocumented policy, posting, transfer, health workforce, norms

Key messages

- Methodologically, the construction of norms from the qualitative data has proven useful to examine the dynamics of health workers' interactions with the Posting and Transfer (PT) systems in the absence of documented policies.
- Some norms are upheld more strongly in their implementation than others
- Absence of documented policy can be addressed by mutual agreement

Introduction

Posting and Transfer (PT) encapsulates a number of health workforce management functions including posting, recruitment, promotion, demotion, and transfer of health workers (Garimella and Sheikh, 2016). It refers to deployment of the health workforce in ways that ensure appropriate numbers and equitable distribution of a motivated and competent health workforce (Sheikh *et al.*, 2015; Garimella and Sheikh, 2016; Purohit *et al.*, 2016).

Good health workforce policies and management are critical to effective health system performance (Dussault and Dubois, 2003; Buchan, 2004). Posting and Transfer (PT) in this context becomes particularly important to ensure good governance, fairness to health workers and their equitable distribution (Abimbola *et al.*, 2017). The evidence from many low- and middle-income countries (LMICs) however suggests that PT policies and practices may be a major impediment to having a motivated health workforce and their equitable distribution (Mcpake and Koblinsky, 2009; Schaaf and Freedman, 2015; Purohit *et al.*, 2016; Abimbola *et al.*, 2017). PT in the public sector has been described as 'Mission inconsistent', implying that PT policies and systems largely fail to optimize health outcomes (Schaaf and Freedman, 2015). The poor implementation of PT results in systems distortions, political interference and corruption (La Forgia *et al.*, 2015; Purohit *et al.*, 2016), and the ways PT systems operate can have implications for the morale of the workforce (Rao *et al.*, 2010).

Although PT is critically important from the governance and health workforce perspective, it remains largely under-researched and under-theorized from implementation, health workforce management and governance viewpoints (Sheikh *et al.*, 2015; Kwamie *et al.*, 2017).

Research from the Indian public health sector suggests that deployment (including PT) policies and their effective implementation are critical in determining the availability and distribution of doctors, though there is a lack of research that examines front-line doctors' experiences with the PT system (Raha *et al.*, 2009; Purohit and Martineau, 2016b). The context of this research study is larger qualitative case study research aimed at understanding the interactions of front-line public sector doctors with human resource management policies and systems, including PT. The aim of this paper is to examine front-line public sector doctors' experience of PT in the context of local policy and regulation.

Methods

Study design and setting

This was an embedded multiple case qualitative research study carried out in two Indian states. The states were purposively selected as two distinct cases, with divergence in relation to geography, demographics, heath indicators and key health workforce indicators. The states' names have been anonymized and they are referred to as State 1 and 2 respectively.

State 1 is a very small state by geographic area, located in north-east India, with a population of <700 000 residents. The literacy rate in the state is well above the national average of 74%. The state has one state referral hospital, four District Hospitals (DHs) (located in the districts and cater to the health needs of the entire district providing mainly tertiary care); two Community Health Centres (CHCs) (30 bedded hospital that constitutes the secondary level of health care catering to 80 000–120 000 semi-rural and rural population at the block level); and 24 Primary Health Centres (PHCs) (rural health centres that cover a rural population of 20 000–30 000). State 2 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 than the national average. The state has >25 districts, 8 government medical colleges, 34 DHs, 243 CHCs and 1656 PHCs.

Data collection and study participants

Document review of the available policy documents and in-depth interviews were conducted. We carried out a web-based and physical search for State policy and regulation documentation to enable a policy review relevant to PT. The web-based search included relevant websites for the department of health, general administration and personnel in both states. For the physical search, the lead author (BP), in person, approached the Department of Personnel in State 1, the Department of General Administration in State 2 and the Departments of Health and Family Welfare in both states. Furthermore, key policy actors were also approached through the support of the local university and personal contacts to gain access to PT policy and regulation documentation.

A total of 61 in-depth interviews were conducted with doctors and key informants (KIs) from both states. As frontline doctors were the subjects of the study, we interviewed 33 doctors—15 from State 1 and 18 from State 2, to examine their experiences of the initial position system. The study used purposive sampling with maximum variation to include doctors in the two states to ensure the representation of: (a) male and female doctors, (b) doctors with different periods of work experience with the health department and (c) doctors mainly working with rural health centres but also some representation of doctors from urban health centres.

However, there were some variations in sampling from the two states. Since State 1 is very small by geographical area, we had representation of doctors from all the districts in this state. As State 2 is one the biggest states in India by geographical area, with >30 districts that are divided into several administrative regions, the sampling used purposive and opportunistic sampling to interview 18 doctors. Initially, we included doctors from three districts that represented a single administrative region, based on physical access. The selection of the three districts was based on the following criteria: (1) one district in close proximity to state headquarters, (2) one remote district far from the state headquarters and (3) one district that is neither too far from nor too close to the state headquarters. We thus included 12 doctors representing the three districts. During the data collection period, there was an opportunity to interview 6 more doctors from districts in other regions attending a training programme at the state headquarters.

We also interviewed 28 KIs—16 from State 1 and 12 from State 2 to get an understanding of existing policies and systems concerning PT as well as their viewpoints in managing the PT of doctors. We used purposive sampling in both states to identify KIs for their views and experiences on the existing policies and research topic, the positions they held in various organizations, institutions and government departments, and the nature of issues that researchers were dealing with as part of a larger research project that included human resource management. The sampling technique thus ensured a wide representation of views of key policy-related actors. The study included KIs at the highest level involved in policy execution in the state; health administrators at the state and district level; individuals representing professional bodies such as the doctor's association; representatives from other relevant government departments and institutions; and representatives from civil society. The interviews with KIs were useful in providing data triangulation with doctors' accounts in the absence of direct access to employment records and policy documents (Walt *et al.*, 2008).

Data collection was conducted by the lead author during January to May and October to December 2018, with 58 interviews recorded with consent and subsequently transcribed by the author in English. Detailed notes were taken for the three un-recorded interviews. The average interview time was 36 min for the doctors and 32 min for the KIs. A total of 23 interviews from State 2 were conducted in a mixture of English and Hindi (official language in India), while the remaining 38 were conducted in English. Interviews with participants were conducted at their offices, with the exception of 6 interviews with doctors conducted in an office at the training centre, with one KI interview conducted at the KI's residence.

Data analysis

The data were analysed using framework analysis, which is matrix-based thematic analysis to arrange and synthesize qualitative data based on the themes generated from the data (Ritchie and Lewis, 2003). A thematic framework containing both a priori and emergent themes was developed. Detailed analysis was carried out using NVivo 12. Job histories were constructed from the doctors' interviews to examine their experiences with the PT system, and quantitative data relating to PT were analysed using duration and frequencies to demonstrate patterns of postings. The multiple data sources used in the research—in-depth interviews with doctors and KIs; and the constructed job histories, allowed for a better triangulation and improved validity (Yin, 2015).

Ethical considerations

Ethical approval was received from the Human Research and Ethics Committee and from the Institutional Ethics Committee (IEC) of at the authors' institutes. Ensuring anonymity of the participants was a key ethical consideration. Informed written consent was sought from all the participants before data collection and participation in this study was voluntary. The study participants were assured of confidentiality at all times. The personal data and transcripts were anonymized prior to analysis and were always kept securely by the lead author. Also, reporting of the data was done in ways that de-linked responses with any identifying information. The identities of the individuals involved in the research and details of the health facilities and districts have not been included in publication.

Findings

Participants' profiles

Doctors were the subjects of the study—15 from State 1 and 18 from State 2. The key demographic and work-related characteristics of the doctors included in the study are given in Table 1.

The 28 key informants were purposively selected to include state-level bureaucrats (3); state-level health administrators (4); district-level health administrators from the health department (5); senior administrative officers from the National Health Mission (NHM) (3); administrative officers from the Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa Rigpa and Homoeopathy (AYUSH) department (3); representatives from the doctors' association who also worked as administrators (4); a head of a medical college (1); a head of a training institute (1); a public service commissioner (1); a professor from a public health university (1); and a representative from an international health organization and a non-governmental organization (2).

Table 1. Doctors' work-related characteristics

Variable	State 1 ($n = 15$)	State 2 ($n = 18$)
Gender		
Male	8	16
Female	7	2
Age (years)	35.11	40.18
(mean, range)	(27–48)	(27–51)
Total service (months)	104	142.53
(mean, range)	(8–264)	(12–396)
Work at current place (months)	38.53	46.13
(mean, range)	(4–84)	(6–108)
Place of work		
Primary Health Centre (PHC)	8	10
Community Health Centre (CHC)	4	7
District Hospital (DH)	3	1

Review of documented policies

The search for documented policies related to PT in both states yielded no results: the authors were unable to identify any policy documentation related to PT, either in hard copy or in a search of government websites. Some study participants including bureaucrats, health administrators and doctors claimed that there was no policy, and that as a result, PT can be arbitrary and unpredictable:

> *There is no policy for Posting and Transfer and that's the biggest worry* (State 2, KI 09: Representative from doctor's association)
> *There is absolutely no basis for transfer, no thoughts, nothing, doctors are just blindly posted* [(State 2, KI 05: Representative (doctor's association) and health administrator at sub-district level]
> *As far as I know, there is no PT policy* (State 2, doctor 02)
> *There is no policy* (State 1, KI 10: District office, health department)

However, analysis of the interviews showed that despite the absence of documented policy, the doctors had expectations of the system and their responses implied policy that applied to specific contexts, expressed in similar and often identical terms, corroborated by KIs.

> *"Yes, I think there is a policy about three years of minimum posting, but I am not fully sure of it as I do not have the policy and have only heard about this three-year posting"* (State 1, doctor 05)

> *I think there is a policy, and these policies are very important. I do not have a copy of the policy, but we must have such rules* [referring to PT rules]. (State 1, KI 02: State office, health department)

Identification of norms

Norms identification and construction

Our thematic analysis reveals a clear set of expectations of PT that were shared by many key policy actors including health administrators and doctors in both states that were referred to by informants without prompting. Where these practices were reported by the doctors and corroborated by KIs, the authors interpreted this as evidence of implied policy, describing them as policy norms. We retrieved the normative data related to this set of expectations, and using an inductive logic, identified six norms relevant to the study. The identified norms were organized into a sequence that reflected the chronology of the PT experience and service priorities confirmed by doctors and KIs. These applied to both States in the study (Table 2).

Table 2. Identified norms that guide PT

Number	Norm	Shortened norm for analysis
Norm 1	This norm implies that postings are made based on service need, with rural locations/centres as the main priority of administrators (especially for initial postings).	Norm 1: service need
Norm 2	Where possible, doctors to be appointed at their native district.	Norm 2: native place
Norm 3	Request for preferred locations may be considered by the health department.	Norm 3: request based
Norm 4	Gendered norms allowing female doctors a degree of protection in two ways: (a) where possible, appointment with spouse in the same district or town[a] (b) avoiding remote postings (first and subsequent postings) for solo females.	Norm 4: gender based 4a: appointment with spouse 4b: avoiding remote postings
Norm 5	The minimum duration of first appointment will be 36 months or more	Norm 5: minimum duration (36 months)
Norm 6	This norm suggests that maximum duration of first appointment be ≤60 months, with the minimum duration established in norm 5.	Norm 6: maximum duration (60 months)

[a]Circumstances relevant to norm 4a were referred to by informants but not personally experienced by any participant, hence this norm has not been examined in the results section.

Identified norms

Six operational norms that underpin the PT system were identified (Table 2), mainly relating to the broad determinants of postings, their location and duration.

Norm 1: service need

There was a common understanding among study participants that initial recruitment of doctors would be at rural and underserved locations (PHCs and CHCs), where the state health department determined doctors are most needed. Implicit within this norm was the 'vacancy condition', with the possibility of appointment contingent upon availability of vacancies.

> *First posting is decided by the health department and is at Primary Health Centre or a rural health centre where the doctors are needed* (State 2, KI 09: Representative doctor's association and health administrator)

> *The health department usually posts the new recruits to the periphery. Even we got our first posting in a peripheral PHC.* (State 1, doctor 14)

> *Posting depends on the availability of vacancies and ultimately on the health department about where it wants to place the doctors* (State 1, KI 08: State office, National Health Mission)

Norm 2: native place

Where possible, doctors should be appointed to their native district.

> *The native place of the candidate is considered while allocating posting* (State 1, KI 03: State office, National Health Mission)

Norm 3: request based

Doctors may request a specific posting, justifying their reasons to the authorities. Where granted, such postings are called 'request based' postings.

> *Postings can happen by request, like a candidate can request and if there is vacancy, then the candidate can get it.* (State 1, doctor 04)

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).

> *Married couples are usually posted at the same locations but there is no guarantee* (State 2, KI 09: representative doctor's association and health administrator)

> *Usually, lady doctors should not be posted in too far and isolated locations* (State 1, doctor 13)

Norm 5: minimum duration

There was a common understanding among KIs that the minimum duration for postings should be at least 36 months, so that doctors spend sufficient time settling into a post, and allowing them to build rapport with the community they serve.

> *Mostly first posting should be in a PHC as we should have work experience of at least 3 to 4 years in PHC* (State 1, doctor 12)

> *I am not sure of the exact policy but there is a kind of 3-year rule which serves as a perk for those serving in rural areas.* (State 1, KI 07: District office: health department)

> *Doctors should only be transferred after 3 years. However, sometimes doctors are needed at ceratin locations so there is no such guarantee that doctors will remain at a post for the minimum 3 years. Transfers may happen within 1 year also* (State 2, KI 06: District health administrator)

Norm 6: maximum duration

Several participants referred to a principle that postings should not exceed 5 years (60 months), together with norm 5

Table 3. Frequency of reference to norms by study participants

Norm	Group 1 Bureaucrats, health administrators and other key actors ($n = 28$)	Group 2 Doctors ($n = 33$)	Total ($n = 61$)
Norm 1: service need	22	24	46
Norm 2: native place	12	10	22
Norm 3: request based	26	31	57
Norm 4a: gender based; appointment with spouse	7	10	17
Norm 4b: gender based; avoiding remote postings	5	9	13
Norm 5: minimum duration (36 months)	8	9	17
Norm 6: maximum duration (60 months)	3	3	6

suggesting a preferred 36 to 60 month posting duration. The main justification given for maximum duration was to prevent abuse of power related to the position.

> *I think the doctor should not stay in one posting for more than 5 years but should remain in the posting for at least 3 years* (State 1, doctor 03)

> *Doctors are mostly posted within 3 to 5 years as this prevents them from taking advantage of their position* (State 2, KI 12: Senior bureaucrat)

Strength of support for norms

The main criterion for identification of norms was corroboration in the accounts of key policy actors (bureaucrats, health administrators) and doctors. To determine the strength of support for a norm, individual unprompted references from the interviews were retrieved and counted. Some variance in description was accepted, provided that it was clear that reference was being made to the same practice. Table 3 shows the relative frequency of reference to the norms, distinguishing references by bureaucrats and health administrators from those of the doctors. Norms 1 and 3 were more strongly supported than others, though similar levels of support for each norm was recorded from doctors and KIs.

Testing performance against norms for first posting

Once the norms were identified, we tested performance of initial PT for all 33 doctors against the identified norms using their job history data (Table 4).

For each doctor, Table 4 shows the location of the first posting and provides evidence as to whether first postings appear to be carried out based on norm 1, service need (peripheral, rural and underserved locations like PHCs or CHCs). Data about norm 2, native place was derived from job history interviews, correlating place of birth and location of first posting. The data on norm 3, request based recorded situations where respondents specifically volunteered that they had made a request that was granted. It does not preclude the possibility that requests were made or inferred—e.g. requests for appointments at place of birth, or with a spouse—but not raised at interview. Data about minimum and maximum duration of first posting were derived from job histories for norm 5, minimum duration and norm 6 maximum duration, respectively.

Norm 1: Service need

Despite the expectation that initial postings would be to underserved/rural locations (based on norm 1), seven of the 33 postings were to DHs and the State Hospital (SH). None of these were reported as individual requests. While not specifically referring to these postings, an interview with a health administrator suggests some flexibility:

> *See, the postings depend upon the availability and need. If there is a vacancy at the District Hospital, we may post a Medical Officer there* (State 1, KI 02: State health administrator)

Norm 2: native place

Nearly half of the doctors (16 out of 33) were posted at their native places, offering some evidence that norm 2 was considered in PT. Five of the seven postings to DHs and SHs were also noted to be at the native place of appointees.

> *I was posted at the District Hospital which is in my own native place. There was a vacancy there and the posting was decided by the health department.* (State 1, doctor 04)

Norm 3: request based

A successful individual request was reported in only 4 of the 33 postings. All of these were at rural health centres and at the native places of the doctors. The quote below explains that the request was granted as there was a need for doctors at that specific PHC location:

> *I gave preference for my first posting at a rural PHC near my hometown and I got it because not many doctors want to go there* (State 2, doctor 03)

While requests were not frequently reported, 31 of the 33 doctors had indicated that request-based postings were available, usually with the qualification that this was granted at the discretion of the state health department. There were 3 doctors who reported a request denied, one a female doctor.

> *I made a request for my first posting for a location in the district, but it was not accepted* (State 2, doctor 8)

> *When it is a transfer initiated by government, we cannot do much there except to make requests* (State 2, doctor 10)

Norm 4: gender based

Of the nine postings for female doctors, seven were posted to rural PHCs and CHCs. There were no reported cases of transfers with spouses, norm 4a. In five cases this was their native place, consistent with norm 2. Two were posted at urban DHs; for one a native place, suggesting compliance with both norms 2 and 4b. For the other, respondent 8, the posting

Table 4. First posting for study participants by health centre, native location, request and duration

Respondent and gender[a]	First posting by health centre (Norm 1)	Native place postings (Norm 2)	Based on Request (Norm 3)	Minimum duration in months (Norm 5)	Maximum duration in months (Norm 6)
1 F	DH	(Yes)	No	(72)	72
2 M	DH	(Yes)	No	(60)	(60)
3 M	(PHC)	No	No	(36)	(36)
4 M	DH	(Yes)	No	18	18
5 M	SH	(Yes)	No	18	18
6 M	DH	(Yes)	No	(60)	(60)
7 F	(PHC)[b]	No	No	8[c]	8[c]
8 F	DH	No	No	(84)	84
9 M	(PHC)	(Yes)	No	24[c]	24[c]
10 M	(PHC)	(Yes)	No	(60)[c]	60[a]
11 M	(PHC)	No	No	12	12
12 F	(CHC)	(Yes)	No	(64)[c]	64[c]
13 F	(PHC)	No	No	20	20
14 F	(PHC)	No	No	12	12
15 F	(PHC)	(Yes)	No	34[c]	34[c]
16 M	(PHC)	No	No	60	(60)
17 M	(PHC)	No	No	12[c]	12[c]
18 M	(PHC)	(Yes)	(Yes)	6	6
19 M	(PHC)	(Yes)	(Yes)	(36)[c]	(36)[c]
20 M	(PHC)	(Yes)	(Yes)	(36)[c]	(36)[c]
21 M	(PHC)	(Yes)	(Yes)	4	4
22 M	(PHC)	(Yes)	No	6	6
23 M	DH	No	No	12	12
24 M	(PHC)	No	No	24	24
25 M	(PHC)	(Yes)	No	30	30
26 M	(PHC)	No	No	(44)	(44)
27 M	(PHC)	No	No	24	24
28 F	(PHC)	No	No	1	1
29 F	(CHC)	(Yes)	No	(84)[c]	84[c]
30 M	(PHC)	No	No	(66)	66
31 M	(PHC)	No	No	4	4
32 M	(PHC)	No	No	(60)	(60)
33 M	(PHC)	No	No	30	30
Total complying with norm	26	16	4	14	8

[a]Doctors 1–15 are from State 1 and 16–33 from State 2; F female, M male.
[b]Bracket indicates that particular norm applied as per the norm conditions.
[c]Indicates the doctors were continuing at the particular first post at the time of interview.

was reported as the most remote and the least preferred of all the DHs in the state, and not their native place. She remained there for 84 months.

> *I think lady medical officers should not be posted at very rural locations. I made a request to be posted near my hometown, but I got my first posting in a very rural PHC* (State 1, doctor 14)

For the remaining 2 female doctors, their postings were very rural locations. Although one of these postings was at the native district of the doctor, the health centre was located very far from their hometown.

Norm 5: minimum duration

At the time of reporting, four first postings had not yet reached the minimum duration. Fifteen of the remaining 29 postings were held for less than the minimum duration of 36 months, inconsistent with norm 5. Thirteen of these postings were for durations of 24 months or less, and in five cases, ranged between 1 and 6 months.

Norm 6: maximum duration

As far as the application of norm 6, maximum duration, 25 of the 33 postings were not consistent with the norm. As noted, in 15 cases the duration did not reach the minimum recommended duration of posting; in 6 cases it exceeded the maximum, with 3 cases in excess of 72 months. Only 8 postings were held for the recommended duration of between 30 to 60 months.

Analysis of validity of norms

In this section, we analyse the face and criteria validity of norms. 'Face validity' is described as 'subjective view and measure of whether a test looks like it is going to measure what it is supposed to measure' (Holden, 2010). 'Criteria validity' is a measure of the 'extent to which operationalization of a construct, relates to, or predicts, a theoretical representation of the construct — the criteria' (Cronbach and Meehl, 1955). To establish validity, we juxtapose the frequency of references made for norms by study participants with the strength of qualitative data (face validity) and patterns of implementation (criteria validity).

Norm 1, service need

There is clear face validity for norm 1, service need, with high recognition by informants, given over two-thirds of both groups volunteered this as an expectation of posting. The pattern of implementation is consistent with the norm, and provides strong evidence of criteria validity, with exceptions explained by recognition of either norm 2, native place or norm 3, request based.

Norm 2, native place

Norm 2, native place, has lower claim on face validity, as it was raised by less than a third of both sets of informants. The claim to criteria validity is stronger, with close to half (16/33) of the postings made to the native place recorded for the doctors, a pattern suggesting recognition of the norm and a pattern of partial compliance. Respondent 8, who complained that despite a request for her native place posting, she was posted to a remote DH, is the exception that proves the rule for the norm, given her expectations.

Norm 3, request based

In all, 57 of the 61 informants volunteered some suggestion that requests could be lodged for postings, usually on the understanding that these would be considered in the light of service need and available positions. This suggests high face validity. There is clear overlap in the operation of this norm and other norms that privilege place of birth and that take gender into consideration. In the job interviews, however, only 4 doctors reported a successful posting on request, each coinciding with their place of birth. Three indicated a request was not granted, providing overall weak evidence of the criteria validity.

Norm 4, gender based

No doctors reported working with their spouse as an issue in their job histories. Examining norm 4b, gender based, avoiding remote postings, suggests that it has limited recognition by either bureaucrats (5/28) or doctors (9/33). Analysis suggests inconsistences in application of the norm with 7 out of 9 female doctors posted to PHCs and one to a remote DH, with a total of 5 at non-native locations. The low level of recognition by informants suggests limited face validity for the norm, and criteria validity cannot be supported from the data available.

Norm 5, minimum duration

Again, norm 5, minimum duration had low face validity, with 8 eight of 28 bureaucrats and 9 of the 33 doctors raising it at interview. In total, 14 of the 31 postings currently meet or exceed the minimum, and in 2 cases, doctors were interviewed during their first posting and had not yet reached the minimum. The level of consistency with the norm is similar to that indicated in norm 2, native place, but with five initial postings lasting 6 months or less, criteria validity cannot be conceded in this case. Shorter first postings may indicate a preference on the part of the doctor, and non-compliance in this case may be perceived as positive.

Norm 6, maximum duration

Norm 6, maximum duration, offers the least satisfactory data for analysis. The norm was raised by only 3 bureaucrats and 3 doctors, with some quantitative variance in their responses on the maximum duration of postings, suggesting very limited face validity. At the point of interview, 8 postings complied with the norm, with 4 exceeding the norm. The value to the doctor of this extended placement is ambiguous: for some, it appeared convenient, particularly where it was in their native place (3 doctors), though where this was not the case it was considered punitive. Hence, we cannot confidently confer either face validity or criteria validity to this norm.

Discussion

Our research on PT was predicated on the availability of documented policies against which to examine the interactions of doctors with the PT systems from two states in India. However, we were unable to identify any policy documentation in either local context. While some informants were adamant that policy did not exist, there was sufficient corroboration between the participants' accounts to suggest that both bureaucrats and administrators and doctors undergoing PT functioned with an apparent consensus that implied policy that applied to specific contexts. From their interviews we have identified a series of normative statements, suggestive of notional policy, described as 'norms' for the current study. For all norms, both sets of informants—bureaucrats and health administrators and the doctors impacted by the norms—showed similar levels of support.

In the absence of documented policies, the study has to address the broad question of whether norms have validity as a proxy for documented policy? To establish the validity of norms, we examined their face and criteria validity, juxtaposing the frequency of references made for norms by study participants with the strength of qualitative data and patterns of implementation. We concede that while norms for service needs and request have strong face validity, followed by the native place norm, other norms do not have strong face validity. Also, only the norms based on service needs and native place have strong criteria validity, while the discrepancies in reporting versus the application of other norms make their criteria validity problematic. Finally, we are unable to concede to criteria validity for duration norms

The absence of documented policies is not a new finding, as studies done in India and other LMICs on PT have reported the absence of formal rules (Banik, 2001; Abimbola *et al.*, 2017). Literature, particularly from the public sector in India reports that PT-related policies and rules may either not exist, can be opaque or poorly implemented (Banik, 2001; Iyer and Mani, 2012; Purohit *et al.*, 2016). Absence of policies and poor implementation of PT can be a major impediment to having an effective, motivated health workforce and their equitable distribution (Mcpake and Koblinsky, 2009; Schaaf and Freedman, 2015; Purohit *et al.*, 2016; Abimbola *et al.*, 2017). In addition to opaque PT policies, poor health workforce management practices in relation to deployment have been documented as a cause of low morale, geographical misdistribution and migration of doctors (Lehmann *et al.*, 2008). Furthermore, even if policies exist, these may be easily bypassed by different actors (Garimella and Sheikh, 2016), making systems open to corruption. Corruption and non-transparent systems may reduce worker morale and could negatively affect the effectiveness of the system (Davis, 2004), hence the need for documented and transparent policies and

their effective implementation. This is at the core of good health workforce governance.

Evidence of the norms from international and related local contexts

With web-based searches, we were able to identify PT-related policy documents and local regulations from India that share commonalities with the norms identified in the current study. In addition, there is support from existing literature around PT from other LMICs about similar norms documented in PT policy (Banik, 2001; Abimbola *et al.*, 2017). Furthermore, we were able to locate the historical origins to the duration norms as well as the phenomenon of frequent transfers experienced within Indian civil services, like patterns observed in the current study (Zwart, 1994; Banik, 2001). The commonalities thus shared between the identified norms and the existing policies, regulations and research from other contexts is suggestive of valid construct of the norms within the existing scholarship.

The documentary support for norm 1, service need, and the vacancy condition implicit within that norm exist in the area of public administration (Banik, 2001; Iyer and Mani, 2012) and from the public health sector in India (Purohit *et al.*, 2016). Further, norm 1 shares commonalities in the way transfers are carried out based on administrative priorities in other LMICs (Kadam *et al.*, 2016; Purohit *et al.*, 2016; Abimbola *et al.*, 2017; Heerdegen *et al.*, 2019).

For norm 2, native place, the preference for appointment to native place, there is contradictory evidence. In a parallel policy document from Gujarat, generic PT rules prohibit postings of civil servants at their native places (Government of Gujarat, 2005). However, in practice, gazetted officers from the health department (including doctors) are an exemption to this rule (Purohit and Martineau, 2016a), and may be posted to their native places, when possible.

The request norm 3, request based, is part of documented PT policy in other Indian states, including Gujarat and Odisha (Kadam *et al.*, 2016; Purohit *et al.*, 2016). Other studies involving doctors and bureaucrats from the public sector in India report similar findings in that the bureaucracy is not bound to comply with requests for PT (Zwart, 1994; Purohit *et al.*, 2016). The request norms form the basis of carrying out PT in other countries such as Nigeria and Ghana (Wurie *et al.*, 2016; Abimbola *et al.*, 2017; Heerdegen *et al.*, 2019). Appointment of spouses to the same facility or location, norm 4a, gender based, is consistent with broad government PT rules for civil servants from India (Government of Gujarat, 2005).

Similar to norm 3, the duration norms identified in the current study have been reported to be part of documented PT policy from the states of Gujarat and Odisha in India (Kadam *et al.*, 2016; Purohit *et al.*, 2016). The patterns of implementation, observed for norm 5, minimum duration, in terms of significantly lower time spent at postings, suggests non-compliance with the norm. Literature from public administration concerning the PT policies and practices of the elite Indian Administrative Servants suggest comparable PT rules that mandate the need to hold a position for 3 years, yet in practice, very few actually hold the posts continuously for 2 years or more (Banik, 2001). The phenomenon of shorter duration of postings, however, is not limited to elite civil servants from India. Studies from the public health sector in India report that doctors are subject to frequent PT (Purohit *et al.*, 2016; Purohit and Martineau, 2016a). Furthermore, research carried out in the health sector in Pakistan reports that health workers hold the postings for very short durations, leading to high instability within the stable jobs that these civil servants hold (Collins *et al.*, 2000).

In addition to the commonalities with the parallel national and international PT policy documentation, we were able to locate historical underpinnings of the duration norms in India. The duration norms were introduced in the British era and originally put in place for different reasons. The ceiling for duration of posting was introduced in the British era to prevent negative consequences associated with long-term postings such as abuse of authority for rent-seeking and taking advantage of the position based on attributed kinship or relationships (Zwart, 1994; Banik, 2001). Consequently, the British government in India used the transfer policy, and used frequent transfers to reduce the opportunities for corruption (Schaaf and Freedman, 2015). The trend for frequent transfer has continued in the post-colonial era for countries such as India and Pakistan, who inherited this system (Potter, 1987; 1988; Banik, 2001). Although a reduction in corruption is still believed to be the primary justification for transfers, frequent transfers may sometimes foster corrupt behaviour such as charging citizens for services that should be free as the officers are not obliged by social ties, and documenting evidence against such practices may not be feasible (Zwart, 1994; Schaaf and Freedman, 2015). The duration norms identified in the current research therefore may be seen as continuity of the formal or the informal rules that provided the basis of PT within the civil services since the British colonial period (Schaaf and Freedman, 2015).

In addition to the existence of PT norms from a local and international policy context, public sector research from LMICs including Togo and sub-saharan Africa treats practical norms as an alternative to policy (Blunod and Koumi, 2017; Herdt and Olivier de Sardan, 2017). We would argue that the commonalities between norms and the documentary support from other documented national and international policy sources, and the historical underpinnings of the duration norms, suggest that they are in fact used as *de facto* policy positions in PT operations, particularly in meeting health service needs for initial postings. The absence of accessible, documented policy and regulation, however, raises significant issues of accountability and transparency, and potentially compromises employer–employee relationships.

Strengths and limitations

The construction of norms for the current research involved careful empirical observations, aggregated through interviews from various policy actors, including doctors. This approach was grounded in the data and premised on abstraction independent of any theoretical preconceptions (Ashworth *et al.*, 2018).

Despite these strengths, however, there are a few limitations and challenges. The first limitation relates to constraints in sampling. The challenges of access in State 2 resulted in a sample combining purposive selection and convenience, which may limit the generalizability of findings.

For those who were continuing at their first posting during the time of interviews, durations at a first posting that are less than the minimum do not provide meaningful insights

into norm 5. However, a current duration of posting that exceeds the minimum or the maximum is relevant to perceived implementation of the norm.

Finally, the norms were constructed from the information volunteered from the interviews, rather than from a structured interview process. This means, not all study participants responded to PT questions in ways that would inform the construction of norms. For instance, while 31 of 33 doctors were aware that posts could be requested, only 4 indicated that their postings were a result of their request, and 2 reported their requests as declined. Thus, failure of the remaining respondents to indicate whether they requested for their first posting or not makes interpretation difficult.

Conclusion

This paper goes beyond the normal discourse of trying to understand the issue of PT from a mere 'policy versus practice dichotomy' that shapes PT outcomes (Schaaf and Freedman, 2015). Methodologically, the construction of norms from the qualitative data is both a contribution to knowledge and a methodological innovation, particularly useful to examine the dynamics of health workers' interactions with the initial PT systems, in the absence of documented policies. In doing so, it contributes to the Health Policy and Systems Research (HPSR) literature. Further research examining the performance of PT against norms would provide a platform for exploring the complex inter-play and relationships between the actors and agencies, critically important in HPSR (Gilson, 2012).

Our evidence suggests that doctors concede that state needs have pre-eminence in decision making regarding PT, with most apparent exceptions readily explained by intersections with other norms. Where norms related to request, gender and duration were inconsistently applied, doctors appear to accept outcomes, based on state priorities, but failure of documentation increases the opacity of decision making, and enables the state to make unliteral decisions, minimizing the grounds for challenge.

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Author contributions

B.P. and P.S.H. conceived and designed the study, B.P. collected the data and carried out initial analysis. P.S.H. provided significant input for data analysis. B.P. and P.H. drafted the manuscript and 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. The authors come from a LMIC and a HIC with diverse backgrounds—one from a health management background in India with several years of experience in conducting HPSR in 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 *2 017 001 666/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.

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