Original Article

Health worker posting and transfer at primary level in Tamil Nadu: Governance of a complex health system function

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Abstract

Background: Posting and transfer (PT) of health personnel – placing the right health workers in the right place at the right time – is a core function of any large-scale health service. In the context of government health services, this may be seen as a simple process of bureaucratic governance and implementation of the rule of law. However the literature from India and comparable low and middle-income country health systems suggests that in reality PT is a contested domain, driven by varied expressions of private and public interest throughout the chain of implementation. **Objective:** To investigate policymaking for PT in the government health sector and implementation of policies as experienced by different health system actors and stakeholders at primary health care level. **Methodology:** We undertook an empirical case study of a PT reform policy at primary health care level in Tamil Nadu State, to understand how different groups of health systems actors experience PT. In-depth qualitative methods were undertaken to study processes of implementation of PT policies enacted through 'counselling' of health workers (individualized consultations to determine postings and transfers). **Results:** PT emerges as a complex phenomenon, shaped partially by the laws of the state and partially as a parallel system of norms and incentives requiring consideration and coordination of the interests of different groups. Micro-practices of governance represent homegrown coping mechanisms of health administrators that reconcile public and private interests and sustain basic health system functions. Beyond a functional perspective of PT, it also reflects justice and fairness as it plays out in the health system. It signifies how well a system treats its employees, and by inference, is an index of the overall health of the system. **Conclusions:** For a complex governance function such as PT, the roles of private actors and private interests are not easily separable from the public, but rather are intertwined within the complexities of delivery of a public service. This complexity blurs conventional boundaries of private and public ownership and behaviour, and raises critical questions for the interpretation of coordinated governance. Hence, the imperative of enforcing rules may need to be complemented with bottom-up policy approaches, including treating PT not merely as system dysfunction, but also as a potential instrument of governance innovations, procedural justice and the accountability of health services to communities they seek to serve.

Keywords: Complexity, health governance, health systems, health workforce, posting and transfer

Background

Posting and transfer: An introduction

As the global call for Universal Health Coverage gathers momentum, several improvements in the health systems of low- and middle-income countries (LMICs) will need to take place to move toward this goal. Of these, the critical need for enhancing the reach and quality of health services is widely acknowledged. LMICs presently face challenges of inadequate number of formally trained health workers and visible gaps in ensuring access to health services for all, and the urgent need to augment health infrastructure and the resource pool of health workers dominates the agendas of global and national task forces on public health.

A common feature of the health workforce in many LMICs is that it tends to be inadequate in quantity, and there are also

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frequently questions raised about the quality and appropriateness of the services they provide.[1-5] Shortfalls in numbers and cadres of health professionals, as well as suboptimal distribution of personnel, are observed and acknowledged as contributors to the poor quality of healthcare and health outcomes in developing countries.[6,7]

An equal imperative, yet one that has not drawn similar attention, is of optimally governing the health workforce. Governance of the workforce plays a crucial role in determining the performance and level of functioning of the health service. Workforce governance entails acquiring, deploying, and retaining a workforce of sufficient quantity and quality to deliver required health services, with improvements in health outcomes as the ultimate goal. Knock-on effects of a well-governed health workforce include enhancing the attractiveness of a well-functioning health service for new recruits and reducing attrition and brain drain, with a potential salutary effect on the related challenge of ensuring workforce adequacy.

Posting and transfer (PT) or dynamic deployment of the workforce is a crucial aspect of health workforce governance and a core function of any large-scale health service. PT comprises a number of activities including postings, recruitment, promotions, demotions, and transfers of health workers. PT policies are important elements of a health workforce planning strategy toward achieving appropriate deployment and utilization of existing human health resources, as well as in planning for the future. PT can also be situated in the regulatory context of attracting and retaining health workers in the public sector and ensuring the accountability of health services, in a broader market environment. Importantly, PT policies and practices affect the goal of equity of health systems through ensuring the availability of human resources and providing services.

A system of rules and norms is required to ensure that the team of workers essential to deliver a required set of services is available where they are required. PT is hence illustrative of the importance of bureaucratic governance in ensuring that health services function optimally with the existing human resources that they have at their disposal. Yet, health services in many LMICs are afflicted with a range of challenges in ensuring appropriate workforce deployment. The persistence of these challenges and their role in impeding the responsiveness and effectiveness of health services in many LMICs has engendered a limited but insightful body of research on the theme.

What do we know: Posting and transfer in low- and middle-income countries

A recent global review by Schaaf and Freedman (2013) highlights that current practices of assigning PT frequently do not help maximize health outcomes or promote norms of health workers professionalism in many countries.[8] Studies from South Asian countries suggest that policies for PT of health workers are frequently ambiguous and arbitrary, presenting a major managerial and organizational challenge.[9-11] Opaqueness of PT policies and a lack of appropriate mechanisms to ensure fair transfers have been reported as important sources of dissatisfaction among the workforce.[12,13]

Irrational PT creates manpower resource mismatches, for example, equipment may be available but without a technician to operate it.[14] Incomplete teams, resulting from irrational postings, mean that specific services are not available,[15,16] for example, the shortage of government medical specialists in rural areas affects the operationalization of first referral units.[17] Getting posted to undesirable locations can lead to staff absenteeism, which affects service delivery.[17] Transfers can change the nature and content of the program being implemented.[18] Critically, long-term needs of users of services are also compromised when frequent transfers take place.[19]

Inequitable distribution/deployment of the workforce and a lack of support staff due to existing PT practices can act as major barriers to the use of services/care. In addition, poor staff skills, attitudes, and overburdening of staff (in the absence of adequate numbers) can directly impact on the quality and effectiveness of care that is provided.[20-22] High frequency of transfers reduces the scope of acculturation, which can directly impact the quality of services that are provided.[17] Frequent transfers reduce the continuity and depth of local knowledge of the workforce, diminish trust and communication between communities and the health system, and impede continuity of care.[23]

Skewed PT practice also results in inequities in the distribution of desirable posts, impacting on morale, and effectiveness of the workforce.[24] PT is widely experienced as being discriminatory and subject to manipulation for personal gain.[11,14,20,22,25] Political influence in PT has been documented to negatively impact staff motivation and quality of services and affect perceptions of well-being among health personnel.[13,17,24] Why do inappropriate PT practices – militating against health service efficiency, responsiveness, and professionalism – persist across so many contexts and countries? Scholars have proffered a number of useful explanatory frameworks. Schaaf and Freedman (2013) highlight the existence of informal economies surrounding PT.[8] Illicit markets for desirable posts and transfers prevail in the health systems of many countries. La Forgia *et al.* implicate the presence of parallel systems – *de facto* institutional arrangements that give rise to practices that are inimical to appropriate service delivery processes and outcomes. The literature demonstrates that far from being a simple problem of enforcement of the rule of law, PT is a complex and contested domain, driven by varied expressions of private and public interest throughout the chain of implementation.[22] This realization is a first step to understanding the persistence of inappropriate PT practices, and eventually to seeking appropriate context-sensitive remedies.

Available literature suggests that in the real world, PT speaks to a varying set of formal and informal goals and objectives of different actors and groups within a complex health system.

PT serves public objectives at a societal level – such as ensuring equitable workforce distribution, accountability, and transparency of health services to communities and responsiveness to their needs. At an organizational level, it may serve a different set of objectives such as enabling the deployment of specifically qualified personnel for appropriate delivery of services and enabling the performance of health facilities to deliver a designated set of quality services. Critically, also PT is intimately linked to the private and individual interests of health personnel including professional satisfaction and growth, personal well-being and security, and direct personal gain through the maximization of opportunities for enhancing privately generated income.

Regrettably, if understandably, mainstream health policies have seldom addressed PT with a full appreciation of these multiple considerations. National health planners tend to view PT primarily as an instrumental function of to ensure the basic functioning of health services. Simplistic and sometimes out-dated public service rules and laws dictate the deployment of health personnel in many countries. Encompassing multiple goals of a health service, impacting on a wide range of actors, and with widespread but poorly understood ramifications for health system performance. PT serves as a critical signifier of how a health system is governed and is as such an ideal subject of enquiry to help understand how rules are interpreted and decisions are made within complex health systems.

We conducted an exploratory study on PT policies and practices in the health sector in four Indian states. The objectives of this study were to investigate policymaking for PT in the government health sector and implementation of the policies as experienced by different health system actors and stakeholders. In this paper, we draw on findings from Tamil Nadu state where a specific PT reform for the "counselling" of health workers has been implemented.

Posting and transfer in Tamil Nadu state

Tamil Nadu is the sixth most populous and the eleventh largest state in India by area. When compared with National Statistics, the Health Status of Residents of Tamil Nadu is considerably above average and has seen a significant improvement over the years.[26] The state of Tamil Nadu has consistently performed well as reflected in its relatively higher life expectancy when compared to the rest of the country and its maternal, newborn, and child mortality rates are among the lowest in the country. These enviable figures in part reflect the contributions of a relatively well functioning and dynamic government health system.[27]

Tamil Nadu state has also benefitted from steps taken to strengthen human resources in the public health system. Creation and filling of posts for health workers at the primary care level is one such step. For example, the number of posts of nurses in each Primary Health Centre (PHC) was increased from one to three making it possible to offer 24 h maternity care. The state has in place several rules, incentives, and enabling policies to attract and retain health personnel in the system. Reservation of 50% of seats at the postgraduate level for doctors serving in the public health-care system is one such example. Medical students completing postgraduation in the state are mandated to work in government medical institutions for a minimum period of 2 years.[12,28] Proactive and centralized personnel management initiatives such as prompt regularizations, promotions, system of counselling for postings, processes of recruitment using merit lists for staff, and provision for recruitment of medical officers on temporary basis enabled filling of vacancies at short notice.[29]

The context of advanced health system characteristics provided an opportunity to effectively investigate processes of governance of the health workforce, and their contribution in meeting the goals of the health system.

Methods

Case studies are particularly well suited to new research areas or research areas for which existing theory seems inadequate.[30] This case study sought to elaborate a PT policy currently in force at the primary care level of the health service and understand health workers' and administrators' experiences of implementation of the policy. Bottom-up or action-centered theories of policy implementation research were applied, in which the investigative focus is on understanding the experiences and relationships of diverse actors engaged in the policy implementation process, and on relating these lived experiences to the written word of policy.[31]

The state "counselling" policy for PT was mapped to illuminate the objectives it served and identify the specific organizations or departments responsible for the implementation of the relevant clause, following an established policy mapping framework.[32]

The lead author conducted 13 in-depth interviews with administrators, doctors, nurses, auxiliary nurse midwives, community and sector health nurses, pharmacists, and technicians, to study the processes of implementation of PT policies enacted through "counselling" (individualized consultations for health workers) based on two PHCs in one health unit district of Tamil Nadu. The two PHCs were selected to reflect different levels of urbanization, a different governance structure as well as the type of PHC. One was an upgraded PHC located in a peri-urban region and came under the jurisdiction of town panchayat, whereas the second one was located in a rural area under a village panchayat. Interview participants were selected to capture a range of experiences (in relation to PT implementation) of different actors at the primary care level. Ensuring anonymity of the participants and the selected PHCs was a key ethical consideration – at no point was the identities of the districts, facilities, and individuals involved divulged. Informed consent was sought from all the participants, and all 13 participants gave verbal consent. Six participants agreed for recording their interviews and consent was sought from them

to permit digital recordings. The remaining seven interviews were recorded in the form of extensive notes by the lead author and an associate. Ethical approval for the study was obtained from the Institutional Ethics Committee of the Public Health Foundation of India.

Thematic analysis of the emergent data on experiences was undertaken, and findings were written up. A combination of structural and reflective analysis was used to analyze the data generated through the in-depth interviews. The structural analysis involved examining case study data to identify patterns inherent in participant narratives, while the reflective aspect of the analysis drew on investigators' memos and notes of their experiences and observations to complement the structured analysis.[33,34]

Results

Posting and transfer policies in Tamil Nadu

PT policies in operation in Tamil Nadu are aimed primarily at ensuring the availability of an adequate number of health workers, especially in rural areas. These policies include compulsory rural postings for doctors and nurses, compulsory government service for 3 years for private postgraduates undergoing course in government medical colleges, incentives for rural posting of doctors, and additional marks for postgraduate seats for working in difficult and remote areas. Opening up of contractual posts in upgraded PHCs to augment doctor numbers is another policy that has been adopted. Doctors registered with local employment exchange are first interviewed for filling the post; in case no suitable candidate is found, selection is done by advertisement after obtaining a "no objection certificate" from employment exchange. While appointing a contractual medical officer, rules of reservation are followed and preference is given to local candidates. These contract medical officers are recruited for the specific upgraded PHC and cannot be transferred to other PHCs

Staff nurses with training in obstetric and newborn care are contracted to serve in PHCs. Nurse recruits may be absorbed into regular time scale of pay after completion of a minimum of 2 years, subject to availability of regular vacancies, and based on seniority and eligibility (Government of Tamil Nadu 2015).

"Counselling" for promotion and transfer

The state government has also introduced a counselling system and issues guidelines for conducting counselling for transfer and promotion of medical/paramedical personnel working in the Health and Family Welfare Department. The guidelines state that counselling for transfer within the directorate will be held once a year. The Director of Medical Education and the Director of Medical and Rural Health Services are expected to conduct counselling for the posts of nurses for transfers and promotions jointly.

The guidelines list a set of criteria and method for promotions and transfers. These criteria stipulate that no mutual transfers are permitted that transfer counselling must be completed before promotion counselling and that promotion must be decided through seniority. The range of objectives that the counselling for transfer and promotion policy is expected to serve with examples from the policy are presented in Table 1 (counselling for transfer and promotion policy: objectives and examples).

The counselling guidelines also detail procedures and criteria for:
a. Ineligibility or limited eligibility for transfer including:

Table 1: Counselling for transfer and promotion policy: Objectives and examples

Policy objectives	Examples from the policy
Efficiency of deployment	Counselling for transfer within the directorate and inter-directorate to be held once a year
	Vacancies to be notified for promotion/transfer to be considered only against those that have occurred due to retirement; death; promotion of incumbents; incumbent on unauthorized leave for more than 2 months and newly created posts
Transparency; Participatory process	Notification of vacancies on official website of the government and notice boards of medical institutions with full details of cause and date from which vacancy arose and consolidated list of vacancies 1 month before the counselling date
	Counselling or re-counselling to be held in a large hall/auditorium fitted with a public address system
Equitable distribution of health workers	Criteria for noneligibility to participate in counselling at the primary health center level includes staff from districts where existing total vacancies are 10% or more
	New recruits to be posted to primary health centers where existing total vacancies are 10% or more
	In primary health centers where no female doctors are available, the vacancies will be reserved for women
Compliance and discipline	Any worker posted to a place after counselling will need to work there for at least 1 year excluding any leave period
	If transferred on administrative grounds or in relation to allegations the person will not be eligible for another 3 years
	If someone if transferred on request they cannot apply for another transfer at least for the next 1 year
Fairness	Promotion to posts during counselling will take into account order of seniority. Within directorate promotional transfers will take into account station seniority whereas for inter-directorate service seniority will be given priority
Maintenance of standards	To maintain quality of services, the government reserves the right to interchange or transfer people occupying the top posts

- Low proportion of current vacancies in the facility to which transfer is requested
- High proportion of current vacancies in the facility out of which transfer is requested.

b. Posting new recruits to fill current vacancies
c. Ensuring an appropriate mix of health workers by specialization and gender, in each facility
d. Notification of PT.

The document also spells out several exceptions to the norms, to be applied in exigent circumstances.

Experiences at the frontline

The following emergent themes characterize the experiences of P and T implementation at the frontline: (1) PT as a coping mechanism; (2) deputation and diversion as an administrative tool; (3) PT as fairness; (4) informal mutual transfers; (5) expressions of hierarchical power; and (6) impact on health system performance. These themes are elaborated in the following sections.

Posting and transfer as managerial coping mechanism

Managerial experiences of the administrators interviewed represent a complex intertwining of personal responsibility and demands from higher officials. The effect of vacancies and transfers on their managerial and other responsibilities is illustrated best through the following quotations:

> *"Busy atmosphere in the PHC and all the work pressure. I get phone calls from my patients all the time. including at nights. Now that all the information is available online, there is always a sense of immediacy. They want to see you (me) all the time. Then because there is manpower shortage, they call upon our staff all the time. There are continuous local adjustments that have to be made" (administrator).*

> *"The MO post has been vacant for about a year now. Because people go for their postgraduate studies, there is a continuous situation of vacancies. We just have to adjust" (administrator).*

Issues related to shortages of staff, some of which may be related to transfers and the associated adjustments that they need to make to keep the centers functional are also highlighted in this quotation:

> *"There are two posts of staff nurses - that have been vacant for some time now. The nurses, who were working here previously, were working on a contract basis. Ever since they have been regularized and transferred, the posts have been vacant. Sometimes, to adjust and fill up posts, we request other PHCs to send their staff-on deputation, diversion, etc., If they are not willing, then we contact the office of the deputy director and ask for a GO (government order)." (administrator).*

Informal negotiations and adjustment processes are often attempted to address the shortage issue, and in the event, this does not materialize the higher authorities are approached, and an official request is made. These processes can also be viewed as elements of coping strategies of the block medical officers (BMOs) that are adapted to suit the routine needs of the facilities they manage.

"Deputation" and "diversion"

Deputation and diversion are managerial strategies used by the administrators to keep the health center functional and provide a certain basic level of service as illustrated in this quotation

> *"We manage through deputation and diversion of staff. The deputation order generally comes from the deputy director's office. It is open ended. As in the duration of the deputation/diversion is not specified. It is just the way of managing things." (Administrator).*

The processes involved in can be both informal and formal. Although these are seen as temporary measures, the participants' experiences suggest that these become long-standing arrangements because of persistent workforce shortages, especially in rural areas.

The typical process is that the BMO makes a request to the deputy director of the health block and he/she then diverts somebody from a nearby center to work at the request place till a replacement can be found and this replacement can be because of another diversion as well. The practice of diversion is restricted not only to the medical staff but also other staff in the centers as well. Several participants did not know when they would be sent back to their original place of work:

> *"For almost 2 decades I worked as a village health nurse in one district, then through a promotion transfer, I was moved to another district. One year into my service there, I was diverted here. I have remained here for six months." (Community outreach worker)*

> *"Diversion is something difficult, because we have to travel another 20 minutes to half hour to our place of work. But no doctor is available so I have accepted it. Till another doctor comes, I will work here." (Doctor)*

Outreach workers tended to be less affected by deputations since their extensive social networks tended to hold them in good stead during temporary transfers to alternative locations. Yet, unexpected transfers were of concern to outreach workers too.

> *"Since it is not seen as a permanent move, there is always a sense of 'will go back' to where they were comfortable and have spent time building relationships, so I am waiting to go back (community outreach worker)."*

"Deputation" and "diversion" emerged as entrenched processes in the health system. It underpinned a constant state of temporariness or flux – with people constantly moving between facilities. The pace of this flux varies across different categories of workers with those at the top of the hierarchy typically moving at a faster pace than the others

Posting and transfer as fairness

The predominant perception among participants was that

counselling is an acceptable mediating mechanism between the authorities and the health worker. There was widespread awareness of the rules in place for the PT, particularly around the number of years after which it was possible to apply for a transfer or promotion. Exceptions on humanitarian bases were also widely known and actively sought including rules permitting unscheduled transfers due to familial and health problems.

"The counselling process if very helpful, at least for me it has been. I wanted to move here because of family responsibilities. I was able to express my problems during counselling and they transferred me here" (technician).

"I wanted to come and work at this centre, during my promotion counselling I made a request and luckily I go it. My family stays nearby and now it is easier for me to be in touch with them" (community outreach professional).

Health workers with long histories within the system expressed that counselling has brought a spirit of fairness to the practice of PT.

"In my earlier days it was not like now. One had to go many times to the higher ups to request to move to another place. With counselling though this has come down and we get to know which position is vacant where and we get to know immediately on the same day of counselling, if we have gotten the transfer" (community outreach worker).

Despite reflections of fairness in the system, there were also some anecdotes of political influence determining PT practices.

"I know someone from another center who has been going to the city and talking to people there. This person has political connection, so who knows; maybe the transfer this person wants will take place. Although officially this should happen only at the time of counselling, I know that people have been transferred at other times" (staff nurse).

Anecdotes about biased and motivated transfers were more common at the upper levels of the hierarchy.

Mutual transfers as an informal process/practice

While the official policy stated that mutual transfers were not allowed, participants acknowledged that there were frequently informal arrangements to this effect. Informal conversations typically occurred in advance of the counselling date when both parties came to mutual understanding and then applied for counselling in a manner that both parties ultimately benefited. This type of informal practice was mainly reported as being attempted for "family reasons" and the need to move to another place, but sometimes, it was also attempted when health workers were unhappy with their immediate superiors.

Expression of hierarchical power

Even as processes of implementation of PT policies were "democratized" through transparent counselling policies, there were also several instances of hierarchical power playing a role in PT. Counselling is seen and experienced as a transparent system by the health workers, but they are also aware and express that fact that it can be used to block and deny transfers. Unions and lay organizations seem to play a crucial role in the implementation of the PT policy in the state. The participants, for example, come to know of availability of vacancies through these organizations, especially in the case of paramedical professionals. In some instances, the perceptions of lay organizations in the eyes of the administrators were reported to influence outcomes of PT requests by health workers who were their members.

However, most of the participants said that punishment transfers are not the norm in the system but do happen occasionally. The participants in general through feel that there has been a decrease in these incidents with several linking this positive trend to the introduction of transparent counselling policies.

Perceptions of impact on health system performance

Very little currently is known about the impact of PT practices on health system functioning. In this subsection, we elaborate on our respondents' perceptions around this question. Responses centered mainly on connected issues of service quality, access, relationships with service users, and morale. The PHC administrators' perceptions show a clear link between transfers, service access, and quality of service including poor service and inability to provide service. This is illustrated in the following quotations:

"If the post is vacant, it should be immediately filled. But because of the shortage we can't do things. Daily 150–200 outpatients are coming in. Single doctors cannot manage all the patients." (Administrator).

"Yes it hampers so many things. The lab tech is there only 2 days. no lab tech is available to take the peripheral smear, and for BS also haemoglobin and urine.the NCD staff is doing only blood sugar." (Administrator).

A combination of shortages and transfers not being effective (replacements for absent personnel not being found) meant that personnel was often overloaded with work. Some participants expressed that although diversion helped in the immediate term, having to be in many places at the same time did impact on the people who use these services. This included the need to constantly refer patients to the next level because of physical inability to cater to the patient load.

There was a widespread perception among the study participants that the constant movement of medical officers affected the performance of outpatient clinics and delivery services. Leadership changes meant reestablishing of team equilibriums and delays in completion of administrative tasks, which in turn affected service provision and the quality of service provided.

Discussion

In this paper, we set out to describe a reform in the PT policy and the experiences of health system actors in the implementation of the policy at the primary care level. The reform in the PT policy has the support of health system actors and was seen as an attempt by the system to make the PT policy implementation processes more transparent, fair, and efficient through "counselling." Health system actors had broadly accepted this reform as a positive organizational development, highlighting benefits by way of ensuring convergence in the expectation and goals between individual practitioners and the system at large, and improving system transparency and efficiency. "Counselling" practices also served to successfully communicate the design and delivery of PT policies to frontline workers – highlighting the importance of balancing command, negotiation, and communication in policy implementation,[35,36]

Micropractices of governance reflected in practices such as "deputation" and "diversion" represent homegrown coping mechanisms of health administrators that reconcile public and private interests and sustain basic health system functions. In the hands of well-intentioned administrators, well-crafted PT policies become an important function to ensure a critical level of system operations and improve performance.[37-39]

Some participants' accounts also highlighted issues of parallel systems and informal economies, already well described by other authors,[8,22] Participant narratives point to a complex picture of enabling and disabling practices, reflecting complexities of systems in general but also the differing expectations, needs and circumstances of different health system actors.

Issues of trust, which we understand as important in well-functioning health systems, were highlighted in a range of ways and attend to the role of trust in teamship among service delivery teams. There were also differing perceptions of clinical and community professionals on whether and how existing PT practices may be affecting trust between the system and its users. Clearly having the right workers posted in the facilities, where they are required is likely to improve communities' trust in government health services, and PT also emerges as a key facet of the accountability of health systems to communities at large.

Beyond a functional perspective of PT, this study also reflects how it embodied justice and fairness as it plays out in the health system. The quality of the relationships between the administration and health workers has been described as an important factor influencing the quality of the relationships between providers and users of care, and the overall effectiveness of a health service as a social institution.[40] Ultimately, PT signifies how well a system treats its employees, and by inference, is an index of the overall health of the system.

Conclusion

PT emerges as a complex phenomenon, shaped partially by the rules, norms and guidelines of the state and partially as a parallel system of norms and incentives requiring consideration and coordination of the interests of different groups. A pertinent observation here is that government servants seek to serve the public interest, not only through literal adherence to the rule of law, represented in this instance by formal government norms and policies but also through a relatively discretionary set of governance practices.

In complex health systems and for a complex governance function such as PT, the roles of private actors and private interests are not easily separable from the public, but rather are intertwined within the complexities of delivery of a public service. The rule, norms, and guidelines are, in different measure, sometimes followed, sometimes subverted, and sometimes ignored, and actual practices tend to resemble acts of negotiation between formal and informal norms. This complexity blurs conventional boundaries of private and public ownership and behavior and raises critical questions for the interpretation of coordinated governance. Against such a backdrop, the imperative of enforcing rules may need to be complemented with bottom-up policy approaches including treating PT not merely as system dysfunction but also as a potential instrument of governance innovations, procedural justice, and the accountability of health services to communities they seek to serve.

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Conflicts of interest

There are no conflicts of interest.

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