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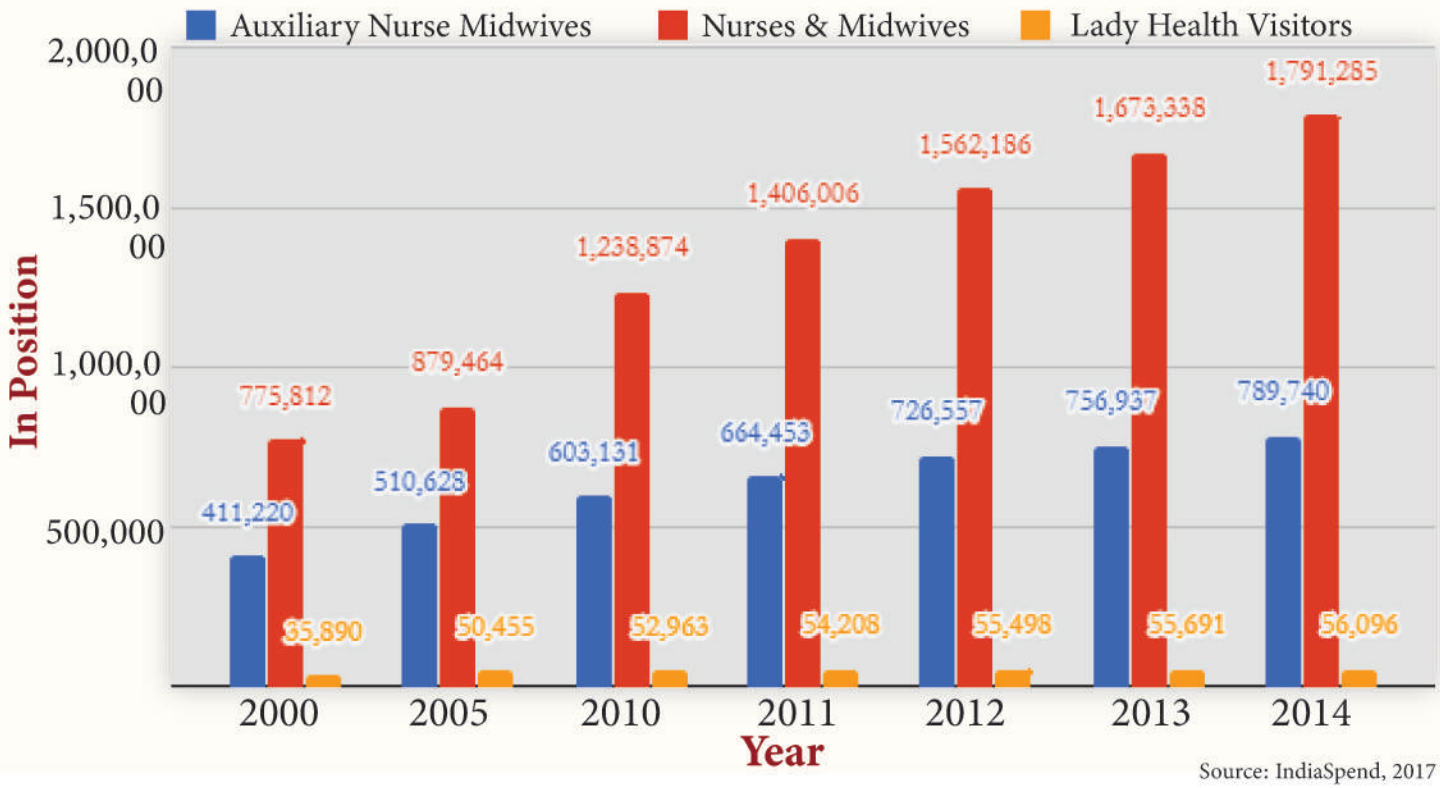
Nurses in India : Precarious employment, migration and resistance

Where are the nurses? A question of numbers

- Nursing is one of the most migratory professions in the country with a global effect on the healthcare system. A worldwide nursing shortage has led to large scale migration of nurses within and outside the country.
- Some studies show that nurses represent 38% of the total health workforce in India, and therefore constitute the largest share of the health workforce (Rao et. al 2008). Assessments vary from 7 to 25 lakhs registered nurses in India (Planning Commission 2013). Such marked variation reflects the fragmentary and unreliable nature of the numerical data on nurses.
- There are an inadequate number of qualified nursing personnel in India, especially in rural areas. This poses a challenge to meeting the healthcare needs in the country. Successive government reports [(Government of India (GOI)2005; GOI 2015; GOI 2017a)], WHO statistics (Anand and Fan 2016), and specialized studies (Gill 2009; Gill 2016) indicate that the nurse to population ratio, as well as the nurse to doctor ratio in India, represent a significant shortage of nursing personnel in the country.
- The shortage of nursing personnel exists in spite of a growth in the number of nursing colleges and government expenditure on human resource development under the National Rural Health Mission (now National Health Mission). The country lags in healthcare expenditure, and in the availability of infrastructure and qualified and competent workforce. India's public health expenditure remains bleak

at 1.4% of GDP, which is lower than many lower income countries (GOI 2017c).

Nursing staff in position, 2000 - 2014



Source: IndiaSpend, 2017

Precarious work conditions, occupational stress and conditions of status

- Due to shortage of nurses, the incumbent nursing cadre is forced to work under extremely unfair conditions. Patients are being denied proper healthcare because of skewed nurse to patient ratio. Situation is even worse in primary health care centers (PHC), where Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activist (ASHA workers) are burdened with the responsibility of managing primary health of the community with little facilities in hand. ASHA workers who are the link between community and medical establishments are mostly recruited from the poorer sections of the society, and are paid a fraction of what is paid to unskilled workers.
- Nurses perform a range of duties and work for long and irregular working hours. On an average nurses work anywhere between 9 to 14 hours a day, especially in private hospitals. For home nurses the work hours are even more erratic. Excessive workload, conflicts with patients' relatives, overtime extracted on a regular basis, and insufficient pay have resulted in psychosomatic illnesses among nurses.
- The nursing profession today is geared towards increasing informalization and casualization, and the interplay of gender, caste and class distinctions have been important in defining the nature and status of their work.

- There is a well-established hierarchical structure of nurses with the well-paid, trained and formally employed nurses occupying the top rung followed by ill-paid, contractually employed and untrained ones in the middle. At the bottom are the daily waged attendants known as private sisters employed on a 'no work no pay' basis.
- The doctor-nurse hierarchy is also influenced by the nature and status of work where nurses are seen as mere 'caregivers'. The intense exploitation of nurses in terms of low pay, long work hours and little participation in hospital policy-making reproduces the misconceived notion of nurses as inferior to doctors.
- Nurses in most central government hospitals are not paid as per the recommendations of pay commission. Nurses in private hospitals are employed under unfair work conditions.
- Even living conditions of nurses in the accommodation arranged by the hospitals is adverse. They live under claustrophobic conditions. The shortage of working women's hostels has augmented the problem further.

Migration of nurses: Patterns and factors

- The adverse work conditions within India have triggered continuous nurse migration outside India and continuous movement between hospitals in India. The post-1980s witnessed mass migration of nurses from India, mostly from Kerala.
- According to Kerala Migration Survey (KMS) data of 2011, the states with the highest numbers of out-migrant nurses from Kerala were New Delhi (31.9%), Maharashtra (19.9%) and Karnataka (18.5%). Other states included Andhra Pradesh (14.9%) and Rajasthan (7.5%). In 2013, the highest out-migration of nurses from Kerala was to the states of New Delhi (34.6%), Tamil Nadu, Madhya Pradesh and Bihar (11.1% each), Pondicherry (9.5%) and Uttar Pradesh (8.8%). In 2016, KMS data showed that New Delhi was again the highest reported state at 57.2% out-migrant nurses, followed by Rajasthan (28.7%) and Maharashtra (14.1%).
- Cross-border migration of nurses from India mostly took place to the Gulf countries because of easier employment criteria than in the developed countries. Studies show that there has been a change in the trend and pattern of international migration.

With the political upheavals in West Asia region, more than female nurses it is male nurses who have continued to apply for jobs in the region.

- The "pull" factor for such migration abroad is the shortage and mal-distribution of nurses and other healthcare professionals across states in many countries. Developed countries have sought a remedy by actively recruiting foreign nurses from developing, lower income countries.
- Studies show that the "push" factor for international migration of nurses is largely due to the fact that nurses in India are not given a high professional status; are paid low and unattractive salaries; get inadequate recognition from the community for their services; and are provided few incentives for quality performance.
- KMS analysis indicates that migrant nurses work predominantly in the private sector. However, there is also a tendency among nurses to work under public health system in Kerala over migration.

Patterns of unionization

- Delhi and Kerala have witnessed the maximum number of strikes by nursing staff against exploitation by hospital authorities. The strike wave of 2009-10 and subsequent strikes in 2011 and 2012 in Delhi-NCR were triggered by the much higher pay, allowances and career enhancement wrested by government hospital nurses under the sixth pay revision (Nair 2010).
- Most of their strikes were carried out independently of established unions and platforms. Established unions of nurses like the All India Government Nurses Federation (AIGNF) also did not intervene in the Delhi-NCR strike wave. Despite the massive strike wave, interventions by the Delhi government were also not adequate.
- Following the Delhi strike wave, new associations of nurses in Kerala began facilitating strikes in private hospitals in the state. Despite strikes breaking out periodically in private hospitals in 2015 and 2017, and Supreme Court directives to implement minimum wages for nurses, the Kerala government failed to act adequately.
- With the continuing agitation of nurses, and emergence of more entrenched and resilient organization, more critical scholarship is needed. The voice of struggling nurses warrants greater documentation for further exposure of the problems with the country's healthcare system and state's healthcare policy.