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Nurses in India: Migration, Precarious Employment Conditions and Resistance

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Introduction:

This paper provides an overview of nurse migration in India by situating such migration in the larger paradigm of how nursing education has evolved in India, how the job market for nursing has developed distinct features over a period of time, and how this skilled work has been subjected to trends of undervaluation. This larger paradigm that fuels particular nurse migration patterns shall be examined in the context of lacunas in the government's public health policy and the resulting unregulated growth of the private healthcare industry. The paper shall also reflect on how nurses have organized themselves in recent times, with a special focus on nurses of private hospitals.

Where are the nurses?: The question of numbers

In India, nursing personnel by and large include auxiliary nurse midwives (ANMs) who have undergone a two year training course, as wells as nurses who have acquired a three year diploma in General Nursing and Midwifery (GNM)[1] or a four year B.Sc. nursing degree which may be followed by a two year post-graduate degree (M.Sc).[2] In addition to this, there is the category of Lady Health Visitors that includes ASHA workers (Accredited Social Health Activists), *aanganwadi* workers, and other community health workers. It is important to know how many nursing personnel exist in the country, and a survey of existing literature immediately points to an essential fact, which is the inadequate number of qualified nursing personnel. A lot of the scholarship rightly highlights the shortage of qualified nursing personnel, which is one of the biggest challenges for the healthcare needs of the country.

[1] The GNM course till 2015 was a three and a half year diploma course. Since 2017 this course has sought to be phased out by the government in the interest of enhancing the quality of nursing education (Nagarajan, 2019a). The last admissions into this three year is stipulated as 2020.
[2] It is the GNM and B.Sc degree-holding nurses who shall be the focus of this paper.

Nursing personnel constitute as the frontline healthcare workforce, whose exact numerical strength, unfortunately, varies from source to source. According to certain reports, nurses represent nearly 38 per cent 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).[3] Such marked variation reflects the fragmentary and unreliable nature of the numerical data on nurses.

Scholars have argued that counting health workers in India is generally a difficult task, and thus the available data is not always reliable. For one, India's health workforce is characterized by a diversity of health workers offering health services in several systems of medicine. Secondly, and more specifically for cadres like nurses, professional councils like the Indian Nursing Council (INC) do not maintain 'live registers' that account for workers/nurses exiting the workforce due to migration, death or retirement (Rao et al., 2016). This is a recognized problem even in official reports of the World Health Organization (WHO, 2007). Nevertheless, whatever the figure of registered nurses in India, most sources point out that a significant number of the total are not necessarily qualified (Rao et al., 2016, p. 136), and that a sizeable number of registered nurses and midwives are no longer in active service. Taking cognizance of this anomaly, recent communications of the INC indicate that efforts are now being gradually undertaken to upgrade the process of registration and tracking of nurses (INC, 2019).

Importantly then, a lot of literature on nursing in India points to a *shortage* of nursing personnel, and more so in the rural areas (Summary Report of National Health Systems Resource Center (NHSRC)). 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. According to the INC India is short of 1.94 million nurses. Another estimate provided by WHO and the Indian Medical Association (IMA) is that India is short of 2.94 million nurses (Senior, 2010; Times of India Bureau, 2016).

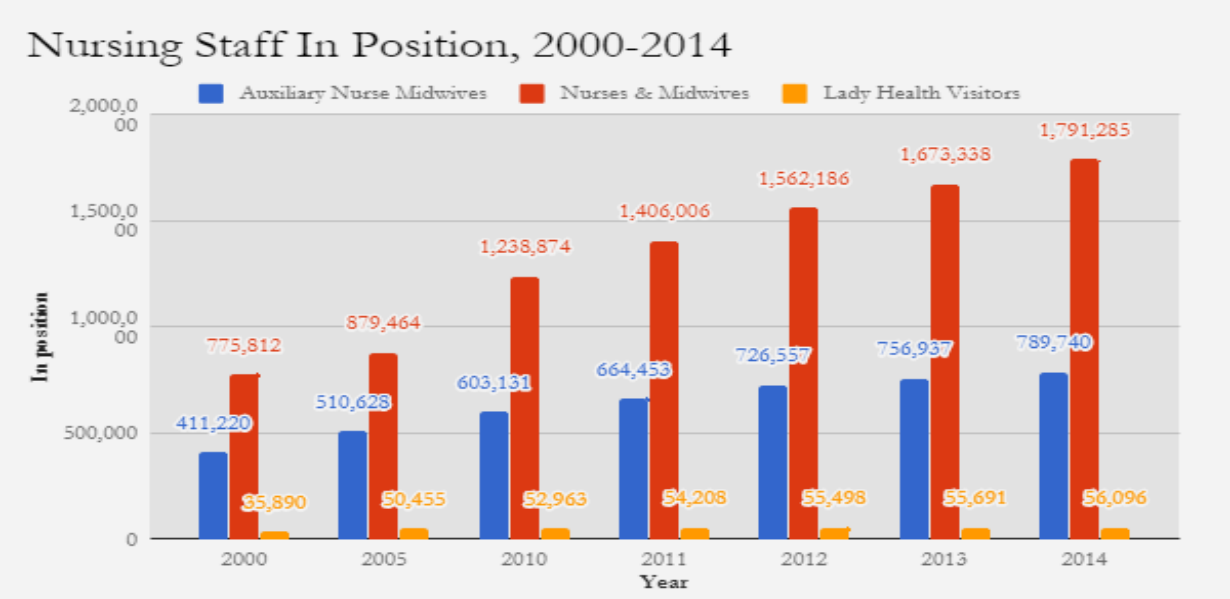
In 2004, the nurse to population ratio found in India stood at 0.80 nurse per 1000 population in 2004 (WHO, 2006). More recently, the 2014 Report of the Steering Committee on Health for the Twelfth Five Year Plan of the Planning Commission indicated that India has only 19 health workers, i.e. 6 doctors and 13 nurses and midwives per 10,000 people in India. The Report of the Steering Committee highlighted a ratio of 1.3 nurses per 1000 population. This small growth since the early 2000s in the number of nurses stands in sharp contrast to the much faster growth in India's population and its healthcare needs – a fact which clearly offsets the more optimistic picture that growth in community health workers has considerably augmented the workforce in India (GOI, National Rural Health Mission, 2013).

[3] The Planning Commission in its *Twelfth Plan Document* placed the figure of available registered nurses/GNMs at 7,43,324.

Indeed, 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]. In fact, it is far from clear as to what extent the recorded growth in the health workforce up till now has reduced the overall deficit in the geographical distribution of nursing personnel. Importantly then, the shortage of nursing personnel is best understood by looking closely at the geographical distribution of nursing cadre across the country,[4] factoring in the attrition rate of nurses, accounting for changing healthcare needs in recent times, and assessing the *real growth* in the nursing cadre by comparing the rate of growth of registered nurses with the rate of growth in India's population.

Figure 1

Figures for personnel registered with the INC



Source: IndiaSpend, 2017

It is important to note that India, according the 2011 Census, is the second most populous country in the world with a population of 1.2 billion. This is a figure which continues to grow and is estimated to touch 1.4 billion by 2030. The increasing life expectancy and changing lifestyles has meant a change in the patterns of disease in the population (GOI, 2017, pp. 2-4).[5] This in turn has created a strong burden of demand on the healthcare industry, which has actually translated into a phenomenal growth of the private sector in the case of secondary and tertiary

[4] A close study of nursing colleges itself reflects that most graduate and postgraduate education is being delivered in private institutions in the South. Moreover, a large number of graduating nurses from the South are seen concentrated in the urban centres, particularly Delhi, Mumbai, Kolkata, Bangalore, Kochi, etc.

[5] Apart from problems related to maternal and child health, nutrition, infectious diseases like tuberculosis, etc., there has been a major surge in non-communicable diseases such as diabetes and cardio vascular diseases and other chronic diseases such as cancer. India is now reporting a large number of cases of diabetes, and respiratory diseases have also increased many folds in the last ten years.

healthcare services. This rise of the private healthcare industry is largely due to limited healthcare expenditure by successive governments on public health. 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). According to recent World Bank data, India ranks 67th amongst some 133 developing countries with regard to the number of doctors, while in respect of number of nurses, India is ranked 75th.

Having said this, a point that can also be gleaned from the literature on the nursing shortage in India is that there is a degree of artificial shortage which exists. There is a large section of the literature that speaks of the growing number of institutions for nursing education in the last fifteen years, but which has not necessarily translated into quality nursing training/education and quality employment. Reading between the lines, we can note that most nursing educational institutions which have mushroomed in India have been those belonging to the private sector. We shall return shortly to the problems posed by a growing number of private nursing colleges.

Private nursing colleges are churning out a significant number of nurses every year, and it is the fast growing private healthcare sector that offers nursing graduates immediate employment. Nevertheless, private healthcare institutions are notorious for employing one nurse for the work of at least two or three nurses, and for imposing very low salaries on nursing staff. This in turn fuels a high attrition rate in the profession. Graduating nurses, thus, face job shortages, and in the case of private sector they are forced to work in very poor working conditions. Steadily, even in the public healthcare sector outsourcing and contractualization of nursing positions, imposition of heavy workloads in government hospitals, and career stagnation within the larger nursing profession has translated into the continuous search for 'greener pastures', and thus a high attrition rate of nurses in India. In this regard, the literature on nursing working conditions and on migration patterns of nurses within and outside India is crucial to fully comprehend the nursing crisis of the country.

Shortage of nursing personnel but precarity nevertheless

The shortage of nurses in India has not worked to the advantage of incumbent nurses. Contrary to being able to negotiate better work conditions and salaries, the incumbent nursing cadre is compelled to work under extremely unfair conditions, which actually prevents them from performing their best. The dismal ratio of nurse to patients has meant that nurses in India are continually being overworked, and that patients are subsequently being denied proper healthcare. Let us look at some more details. Nurses in India work in the ratio 1:20 in most hospitals whereas the prescribed norms of WHO, INC, etc. is a 1:6 nurse to patient ratio in general wards. In special wards the prescribed norm of nurse to patient ratio is 1:4, and in critical wards it is 1:1. On the ground, however, we see nurses struggling to look after patients because of the skewed nurse to patient ratios in these critical wards. For example, nurses at Batra Hospital (Delhi)

claimed that they often had to attend to five patients in the ICU despite the prescribed norm of 1:1 (Centre for Struggling Women (CSW), 2010). Not only did they find such work hectic and stressful, but they also felt concerned for their patients for whom they could have performed better.

Neither does the nurse to doctor ratio match international and INC norms. It is a fact that rather than the 3:1 nurse to doctor ratio, most hospitals operate at a 1.5 or even 0.91:1 ratio. Such practices deny both, doctors and nurses, a work atmosphere that is conducive. Such work ratios contribute to a stressful relationship between doctors and nurses which, in turn has led to the undervaluation of work performed by nurses, and paved the way for the misconceived notion that nurses are 'inefficient' and 'inattentive'.

Figure 2

Nurse—patient ratio according to National Accreditation Board for Hospitals & Healthcare Providers (NABH) recommendations[6]

S. no.	Department/Area	Nurse–Patient Ratio
1	ICU— ventilator beds	1:1 each shift
2	ICU — non-ventilator beds	1:2 each shift
3	High dependency unit (HDU)	1:3 each shift
4	Inpatient beds	1:6 each shift
5	Operation theater (OT)	2 nurses per table each shift
6	Emergency — ventilator beds	1:1 each shift
7	Emergency — other beds	1:4 each shift
8	OPD	As per workload
9	Various procedures	As per workload
10	Labor table	1 nurse per table each shift
11	Supervisor staff	As applicable
12	Infection control nurse	1 for 100 beds

In the primary health centres (PHCs) the situation is no better. Here we find that one ANM is made to look after a 15000-20000 strong population against the prescribed norm of 1:5000 in the plains and 1:3000 in hilly areas. Both ANMs and various voluntary health workers are burdened with the responsibility of managing primary health of the community with little facilities in hand. In the name of primary health care, the government compels these workers to take on such varied responsibilities that most of the time they are being overworked. ASHA workers for example, are delegated work ranging from promotion of universal immunization, provision of first-contact

[6] NABH is a constituent board of Quality Council of India, set up to establish and operate accreditation program for healthcare organizations.

healthcare, spreading awareness, mobilizing the village community towards local health planning, helping ANMs maintain the village health register, and providing aide services for various healthcare programs and government surveys. Apart from keeping their work profiles as broad as possible, the government also forces them to work on incentive basis. The government shamefully recruits such workers from the poorer sections of society only to pay them poorly.

In other words, considering the paltry sums of money they are offered, such health workers are more or less working for free (Kaur, 2018). According to the National Rural Health Mission (NRHM) there are 43 activities which ASHA workers are supposed to engage in depending upon the need of the concerned area. The incentives for task range from ₹1 for providing a packet of oral rehydration solution, ₹15 for preparing a malaria slide to ₹5000 for administering medication to drug-resistant tuberculosis patients (Kaur, 2019). ASHA workers mostly tend to earn from the incentives provided for antenatal care (₹300), an institutional delivery (₹300), family planning (₹150) and immunization rounds (₹100) as cases of other diseases are fewer in number. However, these incentive earnings are disbursed with much delay and fail to cover costs like commuting costs, etc. (ibid). The biggest concern of ASHA workers is that more than enhanced rates of incentives, it is the regularization of their monthly pay or the shift away from the incentive system which is the solution to their rampant exploitation.

Overall work conditions of nurses, occupational stress and the question of status

There are many reasons why nurses always seem hurried for time and 'impatient'. Studies rightly point out that this is due to the workplace atmosphere and working conditions of nurses. Nursing duties include various kinds of responsibilities that range from taking bedside care of patients to managerial roles related to wards. Some of the basic duties of a nurse involve dispensing medication, maintaining patient's progress record, handling and setting of medical equipment, and other administration and assisting chores. There are various levels of skills required in this profession. In the case of critical patients, nurses are expected to have gained experience in specialized skills.

Since the plethora of nursing duties requires a lot of hard work, patience and soft skills, nurse-to-patient ratios, the length of the shift and the number of shifts performed are crucial to ensuring proper execution of prescribed duties without continuous fatigue. However, many nurses work for long, irregular hours, and over one-third of full-time nurses are made to work for 60 or more hours in a week. On an average nurses work anywhere between 9 to 14 hours a day, especially in private hospitals (Mahindrakar, 2016; Times of India Bureau, 2017). For home nurses the hours of work are even more erratic and it is difficult to get leave to attend to personal emergencies. They are treated no better than housemaids (Chengappa and Abraham, 2018).

Ultimately, the intense workloads and skewed nurse-to-patient ratios have reduced many nurses to becoming victims of various psychosomatic illnesses (like acidity, back pain, stiffness in the neck and shoulders, forgetfulness, anger and worry) simply because of the stressful and

unrewarding conditions they have to perform in (Kane, 2009). Research after research on nurses has shown that nurses are stressed at work mainly because they are unable to complete assigned tasks on time (Parikh et al., 2004; Kane, 2009). Stress among nurses is also being attributed to poor management and supervisory practices in several hospitals, including super-speciality hospitals (Jathanna P.N. et al.). The main reason for this stress is the shortage of staff in hospitals, which leads to nurses being overburdened with a larger number of patients, double shifts, etc. Furthermore, stress is also the result of conflict with patients' relatives, overtime extracted on a regular basis, repetitive night shifts, and insufficient pay.

Apart from the stressful work conditions, the status of nurses as healthcare professionals and how they perceive their position has been a subject of examination. Existing scholarship reveals a lot about the huge difference in the status and recognition accorded to doctors as compared to nurses (Davies, 1995; Nair and Healey, 2006; Gill, 2009; Nair, 2012). These studies argue that the prevailing biases against nursing stem from the long-standing concentration of women in this skilled work, and that these biases have sustained a questionable hierarchy between doctors and nurses when it comes to role play. The medical system is heavily influenced by the view of health in which doctors are defined by their scope of practice in *treating/curing* diseases, whereas nurses are seen as mere health promoter/*care-givers* whose duties are directly determined by the doctor and hospital management. This is a biased view that imposes a lower status to nursing (Shames, 1993).

The general view that nurses are simply caregivers or 'angels of mercy' rather than well-educated professionals, has helped to sustain the idea that nurses care but really do not have to think. This is a view which is overtly perpetuated by advertisements that "depict nurses as angels or caring ethereal humans" (Gordon, 2005). In recent times, the lesser status assigned to nursing has been upholstered by enhanced informalization and casualization of nursing duties wherein there has been a fall in the intake of trained nurses and a corresponding influx of ancillary nursing staff/nursing aides who are unskilled or at most semi-skilled. In such a scenario, trained nurses find it extremely difficult to negotiate higher salaries, especially in the private hospitals/nursing homes. In fact, even trained nurses are being inducted for fixed periods of time as interns or trainees in several private hospitals, whereby they are compelled to work at very low salaries (Express Publications, 2018).

The intense exploitation of nurses in terms of low pay, long work hours and little participation in hospital policy making or management keeps the general misconceived notion of nurses as inferior to doctors intact. In actual terms, although the overall work atmosphere may undermine/caricature their role, nurses have evolved into frontline healthcare professionals who have to resort to *clinical reasoning and judgment* regularly when working alongside doctors. The definition of nursing provided by the American Nursing Association is noteworthy in this regard, which states it is "the protection, promotion, and optimization of health and abilities, prevention

of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities and populations."

We also have a number of insightful studies in which nurses' battles of reinforcing the *professional* nature of their skilled work, as well as their negotiations with 'expected' workplace duties in the context of established stereotypical norms of gender, class and caste have been critically examined (Nair and Healey, 2006; Gray, 2009; Nair, 2012; Ray, 2016). In these works, the nursing profession and the problems faced by nursing personnel are contexualized not only within gender inequality, but within an intersection of various forms of inequalities playing themselves out. These studies use the axes of multiple inequalities to situate the still largely female-dominated nursing profession in today's labour market that is geared towards informalization and casualization.

On examination of the low status of the nursing in India, recent research shows that although nurses see themselves as skilled professionals, the society and hospital management does not. In spite of the entry of men into the profession, the continuous inflow of a sizeable number of middle-class women into the profession, recent enhancement of nurses' pay in government hospitals, and the emphasis of professional councils and bodies on the technical, clinical nature of nursing education and duties the negative, stigmatized position of nurses persists in current times. Here the work of Sreelekha Nair, Madelaine Healey and Panchali Ray are noteworthy assessments of the nursing profession in contemporaneous times as they show that more than just an entrenched gender bias, it is more the interplay of gender biases against working women with prevailing caste taboos and class inequality that reproduces a low status for nurses.

The lowly, stigmatized status of many segments of the nursing profession exists despite the evolution of modern nursing from the second half of the nineteenth century as a skilled profession and the steady formalization of nursing work through training, special education, etc. The existing literature explains that professionalization of the nursing cadres has been accompanied by the healthcare market extracting the services of and intensely exploiting the poorer sections of untrained 'nursing attendants' from lower-caste and working-class backgrounds. Certain research has projected this phenomenon as rapidly spreading due to enhanced informalization in the last two decades (Mazumdar, 2007; Ray, 2016).

In the case of contemporary West Bengal, Panchali Ray's work exposes a three-tier pyramidal structure with increasing numbers but descending status, scales of pay, security and regularity of employment as you move down from the apex. At the top are the well-paid, formally employed, registered GNMs; at the middle are ill-paid, contractually employed, unregistered, privately trained ANMs; while at the bottom are daily-waged, unregistered, privately trained "sisters" and attendants who are employed on a "no work no pay" basis.

Such hierarchization is an important point to be recognized since the dynamics of the segmented labour market for care work are the key to any critical analysis that seeks to go beyond a flat

ontology of class, caste and gender inequalities. In fact, it is important for critical scholarship not to flatten the category of 'women' by eschewing distinctions *within* women. It is also important for intersectionality studies of gendered labour to engage with the issue of class and other social positioning by *not* simply projecting them as *additional* sources of exploitation.

Knowingly or unknowingly, recent research seems to have moved beyond simplistic reductions like nurses are exploited on the mere grounds of being women, and seems to indicate that there is an interlocking of oppression in that there are obvious class-based and other distinctions between women in the nursing workforce. For instance, such research has brought out the fact that trained nurses have themselves devolved certain duties to ancillary nursing staff so as to consciously distance themselves from the latter and maintain their higher status in the job market/hospital. Such research indicates that trained nurses have been party to the exploitation of ancillary nursing staff in the process of attaining the professionalization of the skilled nurse status. According to these studies, new hierarchies have consequently been created and consolidated within the profession over time, and these have been steadily mediated by caste and class.

Class/economic status and caste are crucial structuring forces in the labour market, and they interplay in complex ways in the current scenario of growing informalization and feminization of work. While these structuring forces have combined with the proliferation of informal work contracts and feminization of several tedious menial jobs to worsen the condition of historically marginalized groups of women, their role in enhancing precarity has been unleashed on a much larger section of women from diverse social groups. Such nuances require further exploration than what is offered in existing studies. For example, the existing research itself seems to indicate the crowding of *ancillary* nursing jobs by *both* upper and lower caste women.[7] It is also evident from the statements of trade union leaders (Press Trust of India, 2016; Khurana, 2017) that contractualization and outsourcing[8] have crept into different levels of nursing, and is no longer specific to the level of ancillary nursing positions.

Therefore, to further expose the inner working of an increasingly private sector-dominated healthcare sector and the reproduction of social taboos within this sector there is need for a closer study of the social backgrounds of nursing staff across different kinds of healthcare institutions and across urban, semi-urban and rural areas. There is need for closer examination of the relationships between different grades of nurses and attendants in hospitals/nursing homes. There is also need for close examination of contractualization and outsourcing at all levels of the nursing profession.

[7] See interviews of nursing attendants Ritu and Barnamala in Ray, *op.cit.*

[8] Outsourcing refers to employment on contract basis via private agencies. The person/institution hiring hence does not enter into direct contact with the employees. Paramedical positions, nursing positions, sanitation and security services have been opened up to outsourcing in the 2000s and have persisted despite court rulings against the practice. One such court ruling was that of Justice A. Ramalingeswara Rao. See Deccan Chronicle Bureau, 2016.

The following details and discussion shall further shed led on what the existing literature has pointed out about the subordinate status assigned to nursing and the factors which structure day-to-day experiences of nurses.

Pay related problems and other challenges faced as working women

(a) The government sector

In government hospitals, it has taken much struggle on the part of nurses to enhance their pay scales. They have been compelled to struggle to get their basic pay increased so as to match the growing costs of living, and have also had to consistently fight for an increase in allowances like Nursing Allowance, Operation Theatre Allowance, etc. (Central Government Staff News, 2018). It is hard to imagine, but it is a fact that up till the sixth pay commission nurses were not provided a Risk Allowance. Nurses provide direct care, and are hence, in close contact at regular intervals with infected patients. This exposes them to huge risks, especially when work hours are so long that it leads to fatigue. It is precisely when they are tired and overburdened that nursing staff do not follow precautions, which adds to the risk of them getting infected. Considering this, it is inhuman that a large number of nurses in the private sector are not provided a risk allowance at all, or are provided very little in the name of such an allowance in government hospitals.

Under the pressure of an organized movement of nurses in central government hospitals, the sixth pay commission granted an enhanced allowances and entry level pay of ₹9300–34800 with grade pay of ₹4600, which came into force in 2008 (GOI, 2008).[9] However, this revised pay structure continued to be circumvented at the State level and in many autonomous, government-aided hospitals. Till today, for example, in the State of Chhattisgarh, nurses are being denied the sixth pay commission's revised entry level pay in government hospitals, and there is no sign of the revised seventh pay being implemented any time soon (All India Government Nurses Federation (AIGNF), 2018).

Moreover, despite the recommendations of the various pay commissions (and especially the sixth pay commission), nurses continue to feel that they are inadequately paid. As argued by the Trained Nurses Association of India (TNAI), nursing staff are never paid in parity with other professional counterparts like engineers. Engineers in government service who have pursued a three year diploma (Polytechnic) course immediately after the secondary board examination are paid higher than nurses who have pursued a 3 and half years diploma course after their senior secondary examination. This lack of parity in government salaries is also disturbing considering that nurses perform laborious work connected to caring, and also work in more difficult conditions. It has also been highlighted that in government hospitals senior nurses like nursing superintendents do not earn even as much as junior resident doctors.

[9] According to the Gazette Notification No. 470, dated 29th August 2008, the staff nurse/nurse was placed in pay band II which was higher post than lab technicians and lab assistants.

The nurses of government hospitals under the aegis of the All India Government Nurses Federation (AIGNF) have continued to point out the anomalies with respect to entry level pay and allowances under the seventh pay recommendations, given the intense workload in government hospitals (Express News Service, 2016). With the Seventh Pay Revision enforcing a change in recruitment rules, i.e. doing away with GNM qualification for recruitment and replacing it with a GNM plus one year experience qualification, the nurses have had to push hard for a higher entry level pay. It was only in the process of striking work between 2016 and lobbying in 2017 that nurses of government-funded hospitals succeeded in getting a revised pay scale, enhanced grade pay and revision in some key allowances (Public Services International, 2016; Central Government Staff News, 2018).

Government nurses unions, of course, continue to struggle with high workloads, contractualization as well as outsourcing of nursing positions like staff nurse. They are also fighting to expose the career stagnation in the profession. These problems are seen as reinforcing in a major way a rigid hierarchy between health personnel and encouraging the demeaning of work performed by one set of health personnel. When both nurses and doctors are working in stressful conditions (due to the shortage of both doctors and nurses in hospitals), hierarchy created between nurses and doctors by the prevailing system causes doctors to vent their frustration on their 'juniors', which includes nurses.

Hierarchy, of course, also breeds sexist behaviour in the workforce. This is why we find that nurses tend to face sexual harassment by doctors (Chaudhuri 2010; Rao, 2011; Dhaliwal, 2015). This apart, nurses have borne the brunt of sexual harassment at the hands of other hospital staff and visitors due to unsafe work conditions within hospitals that perpetrators have taken advantage of. As women working on night shifts, nurses have long been associated with social deviance by the larger misogynist society, which has led to a backlash from sexual predators in their workplaces. The lack of supporting infrastructure like changing rooms, well-lit hospital campuses, on-campus housing, etc. as well as lack of zero tolerance towards sexist behaviour in hospitals has added to the vulnerability of nurses and facilitated their sexual harassment and sexual assaults on them at the workplace.[10]

As frontline healthcare workers nurses are also subjected to routine acts of workplace violence that involve relatives/visitors of patients. In the overcrowded government hospitals the delay in hospitalization, administering of medication, conducting of tests, deteriorating health, or death of a patient are typical reasons for altercations with healthcare personnel at the hospitals. Nurses

[10] Take for instance the Aruna Shabaung case. In 1973 Aruna was fatally attacked and allegedly sodomized by a male attendant while she was changing in the basement of a Bombay Municipal Corporation hospital, KEM Hospital in Bombay. The hospital failed to provide its nursing staff a changing rooms.

often face the brunt of these outbreaks and struggle to continue working in the acrimonious and volatile atmosphere. Assaults on nurses are, however, less reported than in the case of doctors.[11]

Service conditions of nurses in government hospitals are discriminatory in many other ways. Firstly, while eight hour schedules are advertised by hospitals, both nurses and doctors find themselves doing double duties many times a month. The chronic shortage of health personnel is to blame for this unhealthy practice. According to service conditions, nurses who discontinue for a certain period of time cannot easily re-join service. Considering most nurses take time off to attend to family responsibilities, they find it extremely difficult that majority of hospitals provide no crèche facilities (Madhukalya, 2016).[12] Needless to say, many nurses are forced to leave their jobs due to their inability to manage their work and young children simultaneously. The state has still made no provision of crèche facilities at many of its own hospitals, and nurses who have availed of temporary leave for fulfillment of familial responsibilities find it difficult to avail of promotions. Many government-funded hospitals also tend to deny nurses leave for academic purposes, especially post-graduate studies like research.

The commitment of successive governments in addressing the shortage of nurses in government hospitals and upholding the integrity of their skilled work is suspect, given the steady growth of contractual nursing positions and outsourcing. In response to persistent struggles of organized nurses for recruitment of additional staff so as to correct skewed nurse-to-patient ratios, government hospitals have steadily brought in nurses on contract over the past two decades, and in recent years several government hospitals have even resorted to outsourcing (PSI, 2016; PTI, 2016). The intake of contractual nurses and outsourced nurses in government hospitals have eaten into the unity of nurses, especially with permanently placed nurses questioning the credentials, experience and work ethics of these less securely placed nurses.

The problems with contractualization is, of course, that contractual nurses are rarely regularized and so a bulk of nursing positions are always under the threat of being withdrawn although their requirement exists. These problems apart, it is also important to note how the new recruitment qualifications in government hospitals have proven a boon for the private healthcare industry. With the requirement of one year work experience for recruitment in government hospitals, it is private hospitals that are direct beneficiaries as nurse graduates shall be compelled to gain their minimum work experience from the private sector in order to become eligible for government service.

(b) Nurses of private hospitals

[11] Reports shared by nurses at the Workshop on Issues and Challenges of Workplace Violence in Health Sector: A Step Towards Prevention, organized by Innovative Alliance for Public Health (IAPH), New Delhi, 7 July 2018.

[12] At the press conference called by Maneka Gandhi, Union Minister for Women and Child Development, a ministry official confirmed that most hospitals did not provide crèche facilities in spite of the law mandating that any organization with more than 10 women employees has to have a crèche.

Till recently, the majority of private hospitals openly resorted to the bond system under which nurses were made to submit their license and other original documents with the hospital management for a stipulated period of time. With the Supreme Court and subsequently the Indian Nursing Council coming down hard on the bond system (INC, 2011), it is openly not in practice; though some private hospitals still tend to use it in a concealed manner.[13] The service conditions of private sector nurses continue to be characterized by the non-payment of many allowances like Risk allowance, Night Duty allowance, Travel Allowance, etc.; very low basic pay; negligible salary increments amounting to small amounts like ₹500 or ₹1000; little provision for leave; limited or no subsidized treatment of nursing staff admitted in the hospital; as well as skewed nurse to patient ratios in general wards, and even in ICU and other special/critical wards.

In most private hospitals up till 2009-11 nurses were getting between ₹3000 to ₹7000 in hand in big cities like Delhi (CSW, 2010; Nair, 2010).[14] With seniority, the maximum nurses could earn in such hospitals was ₹9000-10000 prior to the strikes that erupted in many private hospitals across cities between 2009 and 2011.[15] Beyond the confines of the big cities, nurses in many states earned an even smaller amount as they got only ₹3000 to 4000 in hand, and with years of experience could hardly go beyond earning ₹8000. For example, in tier-II hospitals and smaller nursing homes, three year diploma-holding nurses were paid between ₹2,500 and ₹4,000 (Kurup, 2012). In Kerala, before nurses began organizing themselves more concertedly in 2011-12, a diploma-holding nurse was barely earning ₹1500 per month while a graduate nurse was earning ₹3000 (George, 2011).

As of 2017-18, nurses of private hospitals in big cities or in places like Kerala where unionization has been forthcoming since 2011, tend to get anywhere between ₹6000 to ₹11000 in hand.[16] Some big private hospitals claim to pay higher salaries in the range of ₹16000 to ₹17500, but these are still below the minimum wages stipulated by the Supreme court in 2016 (Glassdoor, 2018). Moreover, the basic salary of nurses in private hospital remains very low while the larger component of their salary is incentivized. Consequently, the failure to perform extra duties, etc. results in nurses drawing a meager salary. There is then a constant pressure on nurses to perform more duties, etc. so as to compensate for a low basic salary.

[13] The persistence of the bond system is evident from the writ petition filed by the Trained Nurses Association of India in the Supreme Court in 2016, which sought action against the bond system on grounds of it being illegal and unconstitutional. The Supreme Court subsequently directed the central government to constitute a committee to investigate and look into the concerns of private hospital nurses (Km, 2016).

[14] Nair's is a study in collaboration with the Centre for Women's Development Studies in New Delhi, which found that the entry-level salaries of three year diploma nurses in private hospitals ranged from ₹2500 to ₹6000 prior to the implementation of the Sixth Central Pay Commission recommendations.

[15] Interview of Usha Krishnakumar, Nurses Welfare Association, conducted by the author, New Delhi, 2013.

[16] United Nurses Association (UNA) issued numerous press statements during the April 2018 strike by nurses of private hospitals in Kerala. These low salaries are also confirmed during interviews conducted by the author of striking nurses at Maharaja Agrasen Hospital, New Delhi in April 2018 and at Saroj Hospital, New Delhi in May 2018.

Most of nurses of private hospitals have to send money home from their salaries, pay back educational loans, pay rent for the private accommodations they stay in, plus spend on travel, etc. Nurses are also compulsorily made to perform 6-8 double duties a month, as well as an equal number of night duties that are rarely compensated with corresponding leaves. It is also a practice in many private hospitals to make their own accommodation arrangements for nurses, but such accommodation facilities have been used by the hospital management to extract extra double duties and night duties from the nursing staff availing of the accommodation. In some cases, the nurses are crammed into small rooms and live in claustrophobic conditions (CSW, 2010). Moreover, during strikes the managements of private hospitals have been known to forcefully evict nurses from hospital accommodation and that too while conciliation proceedings are ongoing (ibid.). Despite the fact that private hospital nurses are actually doing overtime, they are being paid ridiculously low salaries. According to nurses, this breeds a workplace culture and perception of their work that routinely makes them feel inferior at the hands of the hospital management, doctors and even patients.

Within this structure, the position of trainee nurses and new comers is extremely precarious. In many private hospitals, a trainee/internship culture has been bred by the management through which nurses' salaries can be kept low. Trainee nurses are new comers who are offered lower remuneration and tied down to the concerned hospital as their original documents in most cases are withheld by the management till they finish their term as trainees. This has come to be known as the bond system. Under the bond system nurses have had to pay huge sums of money, even more than they actually earn, to free themselves from the job contract. These sums are known to touch figures like fifty thousand rupees and more. Many are not even provided experience certificates on completing service. The problem with the bond system came into the public domain shortly after the suicide by Beena Babi, a 22-year old nurse who worked at the Asian Heart Hospital in the Bandra-Kurla Complex, Mumbai. Nurses' organizations proceeded to approach the Supreme Court against the bond system in 2011 and the court ruled against the draconian system (Venkatesan, 2011). Nevertheless, recent press releases show that private hospitals continue to flout the Supreme Court ruling and take work bonds from nurses (Pravasi Legal Cell, 2017).

Raking in huge profits, the expanding private healthcare sector clearly continues to circumvent many labour laws relating to minimum wages, overtime, freedom to exit work contracts, etc., and this has been possible especially due to minimum regulation by the state. For instance, the private healthcare sector has been a key beneficiary of medical tourism. However, instead of sharing the profits with nurses, and not just doctors, these benefitting private hospitals have kept nurses' pay low. They have also created highly adverse working conditions via workplace norms that curb, for example, the freedom of speech. Indeed, nurses allege that sponsors of medical tourism strictly enforce the rule that nurses cannot speak in their mother tongue while on duty – a maneuver targeting the Keralite linguistic group specifically (Harikrishnan, 2012).

What is important to highlight here is that for women nurses the problems seem to grow exponentially. Not only do they have problems at the workplace, but for those staying in private accommodations there is the additional problem of dealing with landlords, intrusive neighbours, etc. This is because of the shortage of working women's hostels in cities. Since local governments provide only a handful of working women hostels in cities, most working women like nurses are forced to take rooms on rent which are near their workplaces. Not only do nurses have to pay a large amount of their salary to landlords, but they also end up being regularly bullied by them. For example, nurses at St. Stephen's Hospital (Tis Hazari, New Delhi), in discussion sessions with the author constantly brought up issues like adjustment problems with landlord/landladies, stalking by men in private colonies where they resided, etc.

It is a fact that nurses of private hospitals and nursing homes are badly exploited, and both the Central and State governments have failed to take any decisive steps to improve their service conditions. Till today no effective measures are taken by the government to ensure some standardization of salaries in private hospitals. It has also turned a blind eye to the cruel bond system under which most nurses in private hospitals are working. Ironically, while it maintains this stance of non-interference, the government simultaneously provides private hospitals land at shockingly subsidized rates. The lack of concern for nurses can be explained by the fact that some politicians sit on the governing bodies or control private colleges-cum-hospitals and therefore have a stake in the profits earned by these institutions; indicating a clear nexus between private hospital owners and government officials/politicians (Phadke, 2016, p.48).

(c) Nursing tutors

Problems, however, exist not only on the field but also for students aspiring for the nursing profession, as well as the teaching staff in educational institutions. While the Indian Nursing Council has prescribed a 1:10 ratio of teachers to students, nursing schools at present employ one teacher to every 25 to 30 students (Bagga et al., 2012, p.38). In such conditions, teaching and practical work is compromised by the sheer number of students in a class. In fact, most teachers are overburdened by their job contracts in nursing schools. The teaching faculty in nursing schools find themselves in extremely unrewarding circumstances. Very few job incentives, i.e. in terms of promotions, adequate salary hikes, etc., actually materialize (Trained Nurses Association of India (TNAI), 2014).

Problems faced by nursing students and the trap of private sector employment

In India, nursing educational programs include Auxiliary Nurse Midwifery, General Nursing and Midwifery, B.Sc (N), M.Sc (N), M.Phil and PhD (N). For students aspiring for a nursing career and nurse researchers, the biggest challenge before them is the lack of government-funded nursing schools and colleges. Government reports themselves indicate that approximately 88 percent of nursing education is imparted through private institutions (MOHFW, Nursing and Midwifery Portal). A large number of nurse aspirants are consequently enrolling in private

institutions; some of which do not meet the State Nursing Councils (SNCs) or INC standards and are eventually forced to shut down (Mohandas, 2008; Parihar, 2012).

Moreover, as per 2016 data released by the INC, out of the total number of nursing educational institutions, only some 20 percent were offering the B.Sc nursing program while approximately 20 percent institutions were offering the M.Sc nursing course and postgraduate speciality courses (MOHFW, Nursing and Midwifery Portal). To take an example, there are only two central government-funded health schools, Lady Reading Health School and Rural Health Training Centre that are equipped to prepare auxiliary nurse midwives. Similarly, the country has only some 14 central government colleges of nursing. Among these colleges, the Rajkumari Amrit Kaur College of Nursing is well-known and is affiliated to University of Delhi. It offers graduate and post-graduate degree programs in nursing, but has unfortunately witnessed phenomenal number of resignations over the years because the nursing teachers do not find themselves at power with faculty members of Delhi University or any other university for that matter (CSW, 2010). Students suffer because there is a lack of staff to teach specialization in post graduate courses.

The biased approach towards nurses is also reflected in the state's approach towards nursing students in training and fresh nurse graduates in internships. Trainee/interning nurses at government hospitals, for example, are paid a very small stipend during their training period; which has usually been less than one-third of the salary of a newly appointed staff nurse (The Hindu Bureau, 2012). Such stipends are inadequate considering the work load that trainee nurses are exposed to in government hospitals. Similarly, nursing students enrolled in government nursing colleges and schools are entitled to a stipend and book grant so as to meet their various needs as students (i.e. for books, stationery, personal consumption, etc.). However, these stipend rates are low, especially at state government-funded nursing colleges and schools, and there have been instances of their discontinuation (Ghosh, 2004). It is only in central government-funded nursing colleges that stipends for postgraduate studies like M.Sc amount to ₹15000 (GOI, 2017d).

The lack of affordable government-funded nursing schools is a big obstacle for all those aspiring for a nursing degree. As of 2017, the National Health Policy documents noted that there existed 1050 ANM, 1541 GNM, and 1160 graduate nursing institutes. Moreover, 388 new post-graduate nursing schools and 8 PhD study centers were notified as part of the implementation of the 2017 National Health Policy. Importantly however, many of the nursing institutes for the ANM, GNM and graduate programs are *private* ones. Nearly 88 percent of nursing education is being imparted by the private sector. This apart, there is also a significant geographical imbalance in nursing education, due to the fact that most graduate and postgraduate education is centered in the southern states of Kerala and Karnataka (MOHFW, Nursing and Midwifery Portal). On the other hand, the highly populous but poorer states in northern India, such as Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh account for only 9 percent of nursing schools in the

country (Rao et al., 2011). Furthermore, the mushrooming private nursing institutes have been known to compromise the quality of nursing education due to their violation of uniform standards and syllabi prescribed by the INC (Evans et al., 2013). And so, even though the INC has introduced syllabus revision for ANM in 2012-13, GNM in 2015-16, B.Sc in 2006, PBBSc in 2006 and M.Sc in 2008, it is questionable whether requisite upgrading of syllabi and training has happened at the State level. This is particularly due to the weakness of the INC's jurisdiction, given that many private institutes easily get accreditation from the State Nursing Councils.

The paucity of government-funded nursing schools forces students to enroll in expensive private nursing schools which charge four to six lakh rupees in fees for a four year nursing degree. Sadly, the quality of training provided in these burgeoning institutions tends to be poor (Nair and Rajan, 2017). Some are even deceived by private institutes which fail to gain recognition from the Indian Nursing Council. These students end up losing the value of a four year long education, and of course, the money they invested. Recently, the Indian Nursing Council pointed out that because many private nursing schools are not registering with it, banks have even stopped giving loans to students interested in studying nursing (Nair, 2019). Overall, banks have pointed out that nurses are a large component of loan defaulters given their limited earning capacity (Chacko, 2012; Tiwari, 2019).[17] The shortage of affordable government-funded nursing schools is actually contributing to the shortage of nursing staff in India because those who are unable to pay for private education opt out of the nursing profession. Intense competition for the few seats in government-run nursing schools and colleges on the one hand, and expensive private education on the other, has really become a nightmare for nurse aspirants. This is most unfortunate considering that the country requires many more nurses.

It is interesting to note the reports and statements of the private industry's lobby groups on the condition of nursing education and shortage of nurses in India. Bodies like the Confederation of Indian Industry (CII) and Federation of Indian Chambers of Commerce (FICCI) have been steadily lobbying for 'reforms' in nursing education that include setting up of "centers of excellence", public–private partnership for nursing programs, merging of GNM courses with the B.Sc (Nursing), mainstreaming of nursing education with medical education, etc. (Bakshi et al., 2010; FICCI, 2016; The Hindu Bureau, 2017). Many of these so-called proposed reforms in nursing education are, of course, focused on further carving out a profitable space for private capital in nursing education and healthcare. These same reports speak positively of a growing healthcare sector and the need to enhance the status of the nursing profession by reducing income disparity, improving nurse–patient ratios in hospitals, grooming nurses for leadership positions, etc. Such posturing by industry and commerce lobbies is highly circumspect, given the ground realities of how nurses are treated in majority of private hospitals and the exorbitant fees

[17] According to records of the Indian Banks' Association, non-performing assets (NPAs) in education have grown in 2018; with those studying nursing courses forming 21.28 percent of the total education sector bad loan portfolio (Tiwari, 2019).

of nursing courses offered in private nursing colleges. It is also important to note the malpractices of private hospitals with respect to nursing students who are attached to the institution. For example, during strikes in private hospitals the nursing students attached to the hospital are brought in as replacements for the striking nursing personnel (CSW, 2010). These nursing students work all shifts and under no supervision. Shockingly, this is a practice noticed even during strikes in government hospitals (AIGNF, 2018).

Unfortunately, instead of creating more government-funded institutions, the government is trying to meet the growing needs for nurses by providing recognition to various private institutes. Of course, these measures do not free nursing aspirants from the problem of high fees. It in fact, plays havoc with their career. Most students, passing out of private nursing schools, for example, are greatly pressurized to find jobs immediately after acquiring their nursing degrees. In this pressure to start earning, and due to the fact that there are only a handful of government hospitals to which they can apply, they join as nurses in private hospitals and nursing homes. Thus, while the country produces nearly 60,000 nurses annually most end up working in the private sector. A large number of nurses migrate to big cities like Delhi which are the main centres for healthcare. Till 2011-12, nurses were tied down to private hospitals for anywhere between one to three years under the cruel bond system, and the problem still persists in some private hospitals as discussed above. *The adverse work conditions within India have, thus, triggered continuous nurse migration outside India and continuous movement between hospitals in India.*

Migration of Nurses: Patterns and Factors

Nurse migration and immigration patterns are closely connected with the current status of nurses in the country. In this regard, existing literature explores multiple "push" and "pull" factors; be it in terms of questionable aspects of government health policies that reduce opportunities of secure employment, concentration of nursing education and healthcare institutions in certain regions, the difficulty of getting and then paying off educational loans, opportunities offered as well as challenges faced in the overseas market, problems with the grievance-redressal mechanism across different kinds of healthcare institutions, and various forms of social ostracism faced by nurses in the larger society in India.

International nurse migration

Studies that have looked at female international migration from India have highlighted that a large proportion are nurses (Percot and Rajan, 2007), as well as domestic workers and fish processing workers from Kerala (Kodoth and Varghese, 2012). It has been noted that nurses from Kerala started venturing out to West Asia from the 1970s, and that the majority of Keralite migrating nurses are Christian (Meija, 1979; Percot, 2005; Nair and Percot, 2007). The post-1980s period witnessed mass migration of nurses from India, and again mostly from Kerala (Nair and Percot, 2007). The existing research has attributed the predominance of Christian Keralite nurses in international migration to the history of nursing in the colonial period. It has been

pointed out that it was Christian missions and nuns that began to invest in nurse training and education. The missionary, charitable approach of Christian nuns led to several young Christian women, many of whom were from lower segments of society, to willingly take up nursing as a calling in life. At the same time, the social taboos associated with disease and contact with bodily fluids in the case of the Hindu community, contributed to the predominance of Christian women in nursing from an early period (Nair and Healey, 2006).

The aforementioned trend of international nurse migration from India has remained visible right into the 2000s; albeit with some important changes emerging, such as the entry of male nurses from Kerala, female nurses from Hindu and Muslim backgrounds and nurses from Punjab (Walton-Roberts et al., 2017).[18] With the recent political upheavals in the West Asia region, more male than female nurses prefer applying for jobs in the region. Indeed, the crisis in many of the countries in West Asia has made the region less attractive. Many Kerala nurses now prefer destinations such as Canada, New Zealand and some of the European countries.

Existing research has amply highlighted the key centers of immigration, the recruitment networks plus strategies utilized by migrant nurses, the workplace conditions offered abroad, the social life of migrant nurses in foreign countries and their social positioning in Kerala as well-earning working women. It has been pointed out that nurses from India have been migrating in significant numbers to the Gulf countries, mostly because of the easier employment criteria. It is considered simpler and cheaper to migrate to Gulf nations as compared to the developed Western countries (George, 2005; Gill, 2009). Among the Gulf countries, the preferred destinations are the United Arab Emirates, Qatar, Kuwait, Oman, and Bahrain as they offer better salary and good quality of life. Saudi Arabia and Yemen are the least preferred destination countries due to more stringent social and religious restrictions.

In India there are three recruitment hubs for transnational nurse recruitment, i.e. Kochi, Bangalore and Delhi. These centers facilitate migration of nurses not only to the Gulf countries but also to Singapore and Organisation for Economic Co-operation and Development (OECD) countries like the US, the UK, Ireland, New Zealand and Australia (Khadria, 2007; Kodoth and Jacob, 2013). In fact, nurses trained in India form a significant portion of internationally educated nurses employed overseas, and come second only to nurses trained in the Philippines (Lum, 2012).

According to the existing research, the "pull" factor for such migration abroad is the shortage and mal-distribution of nurses and other healthcare professionals across states, rural and urban regions in many countries. As a consequence, developed countries have sought a remedy by actively recruiting foreign nurses and other healthcare personnel from developing, lower income countries (Buchan and Scholaski, 2004; Gill, 2016). The much higher salaries and professional

[18] The study by M. Walton-Roberts et al. points out the 42 percent of nurses from Kerala and Punjab are inclined to migrate abroad.

status designated to nursing abroad has facilitated nurse recruitment and appended migration of Indian nurses. Compared to the pittance earned and heavy workloads imposed, for example, in Kerala's private hospitals, the minimum salary offered and work conditions provided in the Gulf and in Western countries is highly attractive. This undeniable fact has induced the steady entry of men, as well as Hindu and Muslim women in nursing schools of Kerala (Percot and Rajan, 2007).

Nevertheless, some research studies caution against romanticizing of overseas work opportunities across the board. Some critical scholarship and news reports indicate the challenges that migrant nurses face in developed countries when it comes to nursing aides who have not cleared requisite examinations and when it comes to poor institutional accommodation, high costs of living, being trapped by fraudulent recruitment agencies, etc. (Basheer, 2004; The Hindu Bureau, 2006; Bhaduri-Jha, 2007; PTI, 2008; Garbayo and Maben, 2009; Mahmood, 2011).

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. These grim prospects of nursing in India is precisely why many nurses in Kerala's private hospitals have kept quiet until recently in the hope of eventually moving abroad after a two to three-year-term in a reputed hospital in Kerala. Their short stints in the state's reputed hospitals are used to build their curriculum vitae. Not surprisingly then, industry watchers say that 20,000 nurses from Kerala migrate overseas every year (The Hindu Bureau, 2018).

Interestingly, existing studies make a distinction between the first generation and second generation of migrant nurses. The former tended to work in the Gulf for a certain number of years so as to earn well, send remittances to their families in Kerala, as well as save for their dowries and future life on return to Kerala. Very few from this generation of nurses went on to work in Kerala after their return, and it was only those who had a good nursing job to come back to in a government hospital as either a matron or nursing tutor who continued their services.[19] The second generation of nurses, meanwhile, has shown more willingness to continue staying abroad, and to use migration to the Gulf as a stepping stone to migrate to Western countries. Returning eventually to Kerala is no longer the *primary goal* of the newer generation of migrant nurses (Percot and Rajan, 2007). Indeed, a lot of the existing literature on international migration of nurses has much to tell about changing family structures and social positioning of nurses in the local community due to the breadwinner status attained by migrant nurses.

[19] Importantly, government hospitals in Kerala allow up to 15 years of leave in block periods of five years maximum at a time. While facilitating government hospital nurses to migrate, such a feature also allows the hospitals to get back experienced nurses. Percot and Rajan, op.cit.

Having said this, despite several important insights the existing literature on international migration of Indian nurses stops short of tracking newer trends of recruitment of nurses from other states of the country. More critical scholarship is also needed which explores the relationship between the dynamics of international migration and the recent unionization of private sector nurses in states like Kerala. Existing literature that has emphasized the predominance of women nurses from petty, rural middle-class backgrounds also appears to warrant a revisit since the social profile of nurse migrants is fast changing, and a significant number of nursing aspirants are no longer from petty rural backgrounds.

Internal nurse migration

It is also worth noting that unlike the well-researched and documented issue of nurse migration to countries outside India, we have fewer studies on internal nurse migration. Information on internal nurse migration is limited. Whatever little we do have is embedded within studies of transnational nurse migration, and such work has highlighted the predominance of Kerala nurses within internal migration as well (Khadria, 2004; Thomas, 2006).[20] The emphasis here is simply on how nurses use employment in big cities in India as a stepping stone for better jobs abroad. At best we come across some impressionistic estimates in journalistic reports. For example, one such media report suggests that 80 percent of nursing staff in Hyderabad hospitals are from Kerala (The Hindu Bureau, 2012). Similarly, we come across an estimate that in Bangalore somewhere between 60 to 70 percent nursing staff are from Kerala,[21] and that close to 80 percent of nurses in Delhi and Pune are from Kerala (Nair, 2011).

It is only recently in 2017 that a WHO-sponsored case study has emerged on both internal and external migration of nurses from Kerala (Rao et al., 2017). For one, this study shows that nursing students and other stakeholders resort to migration to other states in order to access employment opportunities in major cities and leading hospital facilities, i.e. in both the public and private sectors. Students who were interviewed have mentioned institutions such as the All India Institute of Medical Sciences (Delhi), Medcity (Delhi), Narayana Hrudayalaya (Karnataka) and the Jawaharlal Institute of Postgraduate Medical Education and Research (Tamil Nadu) as preferred places of work because they provide higher salaries, harbor greater respect for nurses, are exposed to healthcare advancements, etc. Moreover, this study has drawn on the Kerala Migration Survey (KMS),[22] which has proven to be an important source as it has collected information about persons who were members of a Kerala household during the survey but lived outside Kerala in another part of India. These persons have been referred to as "out-migrants" in the survey. The number of nurse or nurse assistant out-migrants increased from 6564 in 2011 to 7662 in 2013, only to decline to 3862 in 2016. The mean age of these out-migrants increased

[20] In Thomas' study more than half the sample of 448 nurses drawn from several hospitals in Delhi was from Kerala.
[21] S. Bageshree, "The gritty women from the west coast," *The Hindu*, Bangalore edition (March 20, 2012).
[22] The Kerala Migration Survey (KMS) is a large-scale household survey carried out in the state in 2011, 2013 and 2016 by the Centre for Development Studies, Thiruvananthapuram.

from 24.6 years in 2011 to approximately 28.6 years in both 2013 and 2016. Earlier, a larger proportion of male nurses were out-migrants (nearly 32.7 percent in 2011). However, by 2016 this has declined to proportions comparable to their overall distribution within the pool of Kerala nurses (17.8 percent male out-migrants were reported in 2016 while the overall proportion of Kerala male nurses was 22.9 percent the same year).

According to KMS data of 2011, the states with the highest numbers of out-migrant nurses from Kerala were New Delhi (31.9 percent), Maharashtra (19.9 percent) and Karnataka (18.5 percent). Other states included Andhra Pradesh (14.9 percent) and Rajasthan (7.5 percent). In 2013, the highest out-migration was in the states of New Delhi (34.6 percent), Tamil Nadu, Madhya Pradesh and Bihar (11.1 percent each), Pondicherry (9.5 percent) and Uttar Pradesh (8.8 percent). In 2016, KMS data showed that New Delhi was again the highest reported state at 57.2 percent out-migrant nurses, followed by Rajasthan (28.7 percent) and Maharashtra (14.1 percent).[23]

The aforementioned study also analyses nurse migration outside Kerala by examining the issual of certificates of no objection by the Kerala Nurses and Midwives Council (KNMC). These certificates are issued to nurses who seek employment in a state other than where their primary registration has happened. A total number of 9560 certificates of no objection were issued by the KNMC between 2012 and 2016. Over this time period, Karnataka (41 percent), Delhi (31 percent) and Tamil Nadu (14 percent) were the top destinations for nurses seeking employment outside Kerala.[24] A smaller proportion of nurses also sought jobs in Uttar Pradesh (6 percent) and West Bengal (2 percent), and to a very small degree (less than 1 percent) in the states of Gujarat, Rajasthan, Madhya Pradesh, Andhra Pradesh and Chhattisgarh. A particularly steep jump in issuance of no objection certificates was in between 2015 and 2016, and the top three destination states were Delhi, Karnataka and Tamil Nadu.

KMS analysis clearly indicates that migrant nurses work predominantly in the private sector. The KMC analysis further points out that a large number of nurses who leave Kerala also take up work abroad. However, interviews with nursing students indicate a preference among students and existing nurses for a permanent, full-time position under the public health system in Kerala over migration. For many nurses, such a job within the government system would be preferable to working overseas, particularly in the Middle East. Many indicated they would prefer working in the public sector in Kerala or going abroad instead of working in the private sector within Kerala.

Looking beyond Kerala, it also worth noting that over the last decade, nurses from the states of Rajasthan, Haryana and Uttar Pradesh have begun to make significant forays in the profession. The profile of nursing staff in tier-I and tier-II cities has consequently changed significantly to

[23] Ibid.
[24] Ibid.

the extent that Keralite nurses do not appear to hegemonize positions in government hospitals. Nurses from Rajasthan, particularly, have resorted to intense coaching from centres like Jaipur after completing their nursing degree so as to clear the selection examination of government hospitals.[25] This practice has been yielding results in that nurses from Rajasthan are making steady inroads in government nursing recruitment, and in some cases surpassing aspirants from other states like Kerala.

Of course, these emerging patterns of internal nurse migration require closer examination. Scholarship has to be more forthcoming on current nurse recruitment patterns within the country and on output of nursing graduates from various states. Such assessment is also required, given the new developments within unionization of nurses, which, at certain conjunctures reflect unity across regional identities, and at other moments reflect disunity along the lines of regional identities. In this regard, more critical scholarship on internal migration can help uncover ongoing debates within associations of nurses about the alleged neglect of the issues of private hospital nurses by established nurses' unions.[26]

Strikes by Nurses of Private Hospitals and unionization patterns

The literature on strikes and unionization of nurses of the private sector is mostly in the form of news reports covered by regional and national media houses. There are few vision documents of the nurses' trade movement and only a few critical academic writings on the struggles and unionization of private sector nurses (Nair et al., 2016). We shall examine the situation in Kerala and the Delhi-NCR as existing scholarship is focused on these two regions. This is hardly surprisingly, considering Kerala is a major source of nurses who are today working in the private healthcare sector, while the Delhi-NCR is one of the major destinations of nurse migration within India. Understanding the condition of nurses and their struggles in these two areas is thus important.

Delhi-NCR as one of the country's hub for healthcare services has witnessed a number of unprecedented strikes by nurses of private hospitals since 2009. These strikes were followed by a similar outbreak of strikes in Kerala in 2010-11. Taken together, the Delhi and Kerala strikes have been an important move for a largely unorganized work force because they succeeded in exposing how private hospitals; be it hospitals run by charitable trusts, nursing homes, or hospitals run by doctors, or large 'five' star hospital chains; were brazenly exploiting nursing staff. Strike action has also been a brave move, considering that the contracts of nurses can easily be terminated by hospital managements. Indeed, many nurses at the forefront of these strikes

[25] The author conducted an interview with nurses from Rajasthan, who were employed at All India Institute of Medical Sciences (AIIMS), New Delhi, May 2018. Nurses from AIIMS pointed out that although the clinical training and even the degrees of some the Rajasthan nurses appear to be questionable, 160 of them cleared the written test for 200 odd nursing posts advertised by AIIMS. According to these sources, this trend has existed for some time now.

[26] The point of neglect was vocally expressed, for example, by nursing leader, Jashmin Shaw, in his speech at International Nurses' Day Conference, Ram Manohar Lohia Hospital, New Delhi, 10 May 2015.

have been victimized, and a large body of striking nurses moved out of the concerned hospitals within a year or two of the strike and settlement. This, of course, allowed the private hospitals to slide back into the pre-strike conditions with the intake of new nurses. Thus, in Delhi the salary hikes have been slow in spite of the strike wave of 2009-10.

Observations from Delhi-NCR Strikes

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. With the considerable salary hike in government hospitals, the nurses of private hospitals were emboldened to resist the low salaries and bond system imposed by the private healthcare sector (Nair, 2010). At this conjuncture, salaries ranged anywhere between ₹6000 to ₹8000, after provident fund deductions, etc.

Their strikes were carried out independently of established unions and platforms. Some were short-lived (two to three days), while some extended to 15 to 20 days (CSW, 2010). The strikes remained *individuated* as they broke out hospital by hospital and were led by somewhat spontaneously formed associations at the level of each concerned hospital. It was these associations that had issued the strike notice and managed the day-to-day logistics of the strike.

On certain occasions, leaders of established trade unions like Centre of Indian Trade Unions (CITU), All India Trade Union Congress (AITUC), etc. visited the striking nurses but further coordination was lacking. Moreover, established unions of nurses like AIGNF did not intervene in the Delhi-NCR strike wave. Community ties and network were instead actively tapped by the striking nurses of private hospitals. Assistance from local Malayali Associations, Malayali lawyers and Kerala MPs was mobilized.[27] Typically, while some form of conciliation was being undertaken by the labour commissioner of the area, the striking nurses also reached out to individual Kerala MPs, who were requested to visit the concerned hospital authorities and impress upon them the need for a fair settlement. In some of these strikes, Usha Krishnakumar, who was heading the Malayali Nurses Welfare Association, and is the spouse of the former Union Minister S. Krishnakumar, was contacted to negotiate on behalf of the nurses. Needless to say, the desperation for a resolution to their problems and their search for an 'able' negotiator beyond their ranks ultimately allowed community chauvinism to prevent the striking nurses from engaging with the political opportunism of many of these Kerala MPs. Thus, the question failed to arise from the various strikes as to why the Kerala MPs were not raising the issue of rampant exploitation of nurses of the private sector in the Parliament.

The strikes, though often coinciding, did not culminate in a common platform of pressure building on the local administration, Labour Department and Health Ministry (CSW, 2012).

[27] Interview of nurses of Asian Institute of Medical Sciences (Faridabad) and QRG Central Hospital (Faridabad), conducted by the author, May 2012.

Having said this, the strikes at the individual level of each hospital succeeded in mobilizing the majority of nurses, and female nurses were visible in their participation. Leadership, nevertheless, tended to be mostly in the hands of male nurses. The nurses had not only to tackle the hospital's hostility but also anxious and continuous pressures from home about their decision to strike. In this context, nurses often assisted each other by tackling the queries and/or admonishments of each other's relatives. Reportage of their strikes by Malayali newspapers and news channels were a significant boost for them as it was seen as a vindication of their demands, as a public shaming of the management, and as an avenue for outreach to external 'leaders'.

The strikes were tackled with much high-handedness by the management of respective hospitals. It was not unusual for the management to unleash the terror of goons and bouncers on the striking nurses. The picketing nurses were often heckled by goons at their strike venues, and in some cases of resulting altercations, male nurses had false FIRs lodged against them by the management. To break the back of the strike, especially when it persisted beyond a few days, the management of private hospitals brought in nurses to replace striking nurses by using services of placement agencies. In one instance involving the hospital attached to Sharda University in Greater Noida, the nursing students of the University's nursing school were brought in for regular shifts during the nurses' strike in 2012. The striking nurses often questioned the credentials of their replacements and sort to thwart the joining of nurses from placement agencies.[28]

Of course, the scenario also reflected another crucial fact. For one, the relative ease with which nurses from agencies were mobilized busted the myth of nurses' shortage. Secondly, such practices also revealed the tremendous vulnerability of nurses who were brought in by placement agencies during strikes and were fired shortly later. Another tactic used by the hospital management was to issue eviction notices to the female nurses residing in accommodation provided by the hospital. In one case, during the period of negotiation between the striking nurses of Asian Institute of Medical Science Hospital, Faridabad, the management went to the extent of cutting off the water supply and also installing jammers in the hospital-provided accommodation of nurses so as to prevent them from communicating on the phone.[29] It was only when the nurses raised the matter with the district administration that the hospital management was hauled up.

However, despite all these odds the nurses of Delhi-NCR private hospitals gave their hospital managements a difficult time. The Delhi Government did proceed to take note of the strike wave, as was evident in Health Minister Kiran Walia's statement (Perappadan, 2010). However, little concrete action followed in terms of the Delhi Government enhancing regulation of the private

[28] Interview of nurses, conducted by the author, May 2012.

[29] This harassment was described in the accounts of nurses from the hospital, and further elaborated in an interview with activists of United Nurses of India (UNI). The said strike broke out in May 2012. Also see the statement issued by the Joint Action Committee of the strike, 2012.

healthcare sector. Some relief came in the form of the Supreme Court judgment against the bond system. This development was the result of the 2009-10 strikes that led to some independent associations of nurses filing a petition against the bond system in the Supreme Court. In fact, these independent associations of nurses have been taking active recourse to the courts, but such action has rarely been supported by consistent efforts to organize the private sector nurses on the ground. Hence, strike activity rarely culminated in long-standing unionization, especially with the high attrition rate of the nurses and the neglect of union building.

Importantly, the Central Government went onto respond to the periodic strikes during this period with a new piece of legislation, the Clinical Establishments Act, 2010. This legislation has been poorly enforced in Delhi-NCR, and private sector nurses have largely thrown up only fleeting organization and unity. Consequently, salaries of nurses have stagnated at anywhere between the paltry sum of ₹9000 to ₹13000. This salary structure is way below the minimum wages stipulated for such skilled work and is in contravention with the spirit of the Supreme Court ruling of January 2016 that directed the Central Government to look into the pay structure of nurses in private hospitals.

Since 2017 the Delhi-NCR has witnessed a level of greater organizational effort on the part of private sector nurses, and strikes have again broken out. The recent strikes in Delhi are supported by the United Nurses Association (UNA), which appears as an umbrella organization that is trying to bring together a larger unity of nurses spread across different private hospitals. Under UNA's guidance, Malayali as well as north Indian nurses seem to be organizing themselves at the level of their hospitals and at the level of the industry itself.[30] This is a development that requires closer study and such examination can reveal a lot about whether nurses of private hospitals have moved beyond their experiences and strategies of 2009-12.

Observations from Kerala

Following the 2009-10 Delhi strikes, new associations of nurses in Kerala such as United Nurses Association (UNA), Indian Nurses Association (Kannur), Indian Registered Nurses Association and Indian Private Nurses Association (IPNA) began facilitating strikes in private hospitals in the state (Biju, 2013; Nair et al., 2016). These strikes forced the Government of Kerala to set up the Balaraman Committee, which made several landmark recommendations.[31] Consequent to this, revised minimum wages for private health sector nurses were fixed by May 2013. Nurses of private hospitals have subsequently kept pushing for implementation of recommended minimum wages and the periodic review of pay structures in private hospitals. Strikes have broken out

[30] UNA has reflected an understanding on the necessity of more coordinated action by organizing, for example, collective agitations on the nurses' concerns in Jantar Mantar, Delhi. UNA's approach towards bringing Delhi-NCR nurses together on the issues of a minimum salary that corresponds to the minimum wage rate for skilled work as stipulated by the Government of Delhi is evident in the representations made by the UNA. Interview with Mr. Rince, executive member, UNA, February 2019.

[31] A summary of the Balaraman Committee's recommendations have been made available by the Qualified Private Medical Practitioners Association.

periodically in many private hospitals in Kerala in 2015 and more so in June-July of 2017 (PTI, 2017).

Growing pressure from below and a Supreme Court judgment in January 2016 (Km, 2016) to look into the pay structure of nurses in private hospitals led to the Central Government constituting a committee headed by senior bureaucrat Jagdish Prasad. The committee recommended that minimum salary of nurses working in private hospitals with less than 50 beds should not be less than ₹20,000 a month. In hospitals with 50-100 beds, it was recommended that the nurses should get not less than 25 per cent of the salary of their counterparts in government sector; and those with more than 100 beds, should pay nurses not less than 10 per cent of similar scales in the public sector. The Kerala chapter of Association of Healthcare Providers (India) has been opposing the 2017 directives of the Kerala Government, and the Kerala Government has failed to get the private hospitals to adhere to its orders seeking compliance with the Supreme Court directive of minimum wages for nurses at Rs. 20,000. This administrative paralysis has triggered a big strike by nurses in April of 2018 (Nair, 2018).

Clearly, Kerala is the epicenter of a militant movement of nurses tied to the private healthcare sector. Crucial insights on the movement have been provided in the work of Sreelekha Nair, S. Timmons and C. Evans. Such work has discussed the social background of the nurse leaders, the issues around which the nurses have been organized, the modus operandi of the strikes, the response elicited by agitating nurses, and the limitations with the Kerala Government's intervention. Nevertheless, 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.

Conclusion

The exploitation of nurses is linked to the way our economy functions. The economy determines the way women enter the labour market for jobs and the way they are treated at their jobs. Today the economy is driven by the interests of private profit, which is why we increasingly see privatization of state-units, i.e. state industries, hospitals, schools, colleges, transport, etc. This has resulted in the reduction of government jobs, which compels more and more people to work on contract at private jobs. For private businesses that are now growing exponentially due to privatization, profit must be earned at whatever cost. This is why private undertakings constantly try to bring down their expenditure on labour. In this process they have brought down wages, increased working hours, and basically, reduced the standards of working conditions.

In the era of neoliberal economic policies, we have seen a rapid growth in the private sector, and the consequent withdrawal of state investment in the social sector. As a result, there has been a decline in the number of hospitals run by the government, and a fall in the quality of services provided in existing government hospitals. We have also seen inconsistent state funding in

nursing education, which has led to many nursing aspirants to fall trap to the vicious cycle of educational loans for private education.

In such a scenario, the overall position of women as a workforce and their position in society have seen some unfortunate developments. Firstly, the majority of women are increasingly concentrated in the lower segments in the labour market where work contracts are highly casualized, pay is low, and jobs are mostly menial ones. Private business interests and even government undertakings have, in fact, consciously kept certain kinds of jobs open for unskilled labour. Unskilled nursing orderlies and attendants that are crowding government and private hospitals through outsourcing are indicative of this problem. Such nursing personnel are paid badly, hired and fired freely, and even sexually exploited under promises of employment.

While trained nurses are not an unskilled workforce, they too are discriminated and exploited precisely because of the way the economy is functioning. We know for a fact that the system perceives both unskilled and skilled women workers as a docile workforce. This is why working women like nurses are denied basic facilities at work like crèche facilities, easy access to maternity leave, etc. Currently the healthcare system in place perceives nursing as a subordinate profession to the profession of doctors, and this appears to be linked to historically constituted projection of nursing work as an extension of certain 'feminine' roles or duties that are an extension of those which 'naturally' come to women. Nursing, in spite of its many segments of skilled work, is taken as a more 'feminine' job, and the high concentration of women in the profession is ample proof of this. Indeed, for years women have been 'encouraged' into certain professions like nursing. This has been done by simply making certain other professions more difficult to attain, and by creating a stigma in society against women who do come forward for the more 'male jobs'. Having said this, there are other contributing factors as along the lines of caste and class distinctions that have ascribed nursing the status it has today as an occupation.

With the 'feminization' of particular professions the current system has also introduced lower wages for them by projecting these professions as less skillful. As a result, work performed by women in certain professions like nursing comes to be looked down upon by other professionals in the same field. Because of the way nurses are paid and perceived, doctors too end up disrespecting nurses. To sustain this biased treatment of a workforce like nurses, the system also creates rigidity in the health profession. It creates very little opportunities for career enhancement in nursing itself. Most begin as staff nurses and retire as staff nurses or retire at the post of nursing sister, which amounts to basically one promotion. The system also denies nurses the opportunity to become doctors after a certain period of service and further education in medicine. Thus, once a nurse, always a nurse. Such rigidity does not develop a genuine sense of dignity of labour performed by nurses, among other colleagues in the health field. It also ties people down to one job profile for their whole life, in ways similar to the caste system which used to assign people particular professions for a lifetime. Recently, the draft national education policy of the Government of India has envisaged "lateral entry" of nurses into the MBBS course (Nagarajan,

2019b), but it is too early to tell whether such policies will actually allow for adequate opportunities for nurses.

There is a silver lining to this grim context of long migration patterns, and growing contractualization, outsourcing and feminization of nursing work. This silver lining can be seen in the steady unionization and ongoing struggles of many sections of nursing personnel. The spurt of organizational activity and struggles of nurses in the private sector are particularly noteworthy, given the context of the expanding private healthcare sector.

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