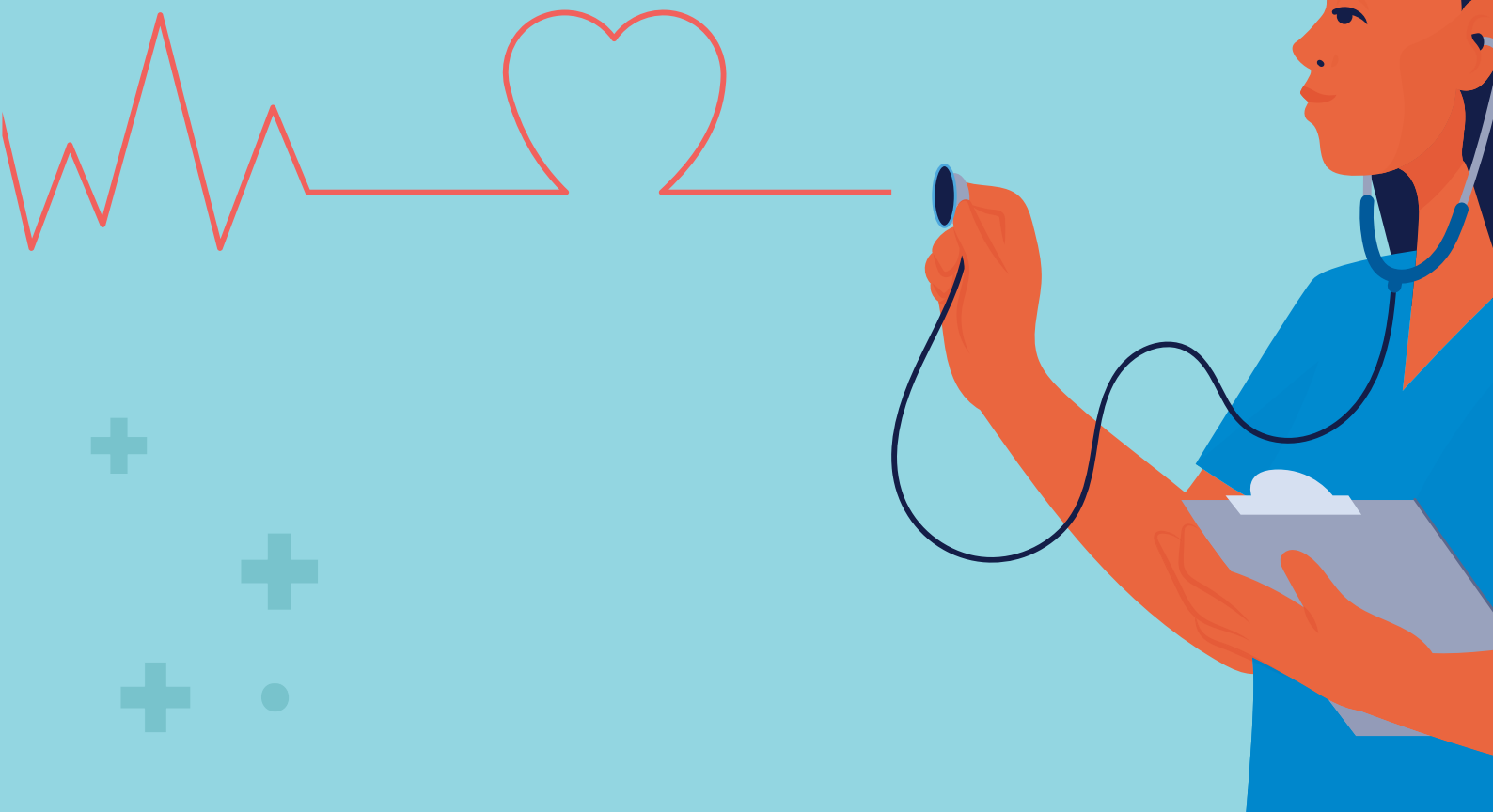


A study on employment and
working conditions of
**nurses in
private hospitals
in Delhi**



Employment and working conditions of nurses in private hospitals in Delhi: an exploratory study

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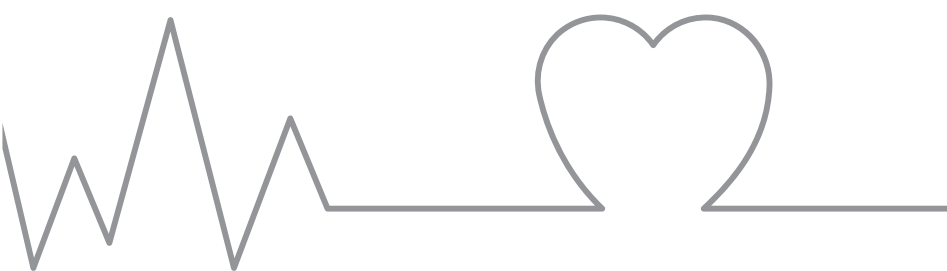
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Abbreviations

AIIMS	All India Institute of Medical Sciences
AHPI	Association of Health care Providers of India
ANMs	auxiliary nurse midwives
BSc	Bachelor of Science
CL	casual leave
CEO	chief executive officer
CNO	chief nursing officer
DHC	Delhi High Court
DNHRA	Delhi Nursing Homes Registration Act
DPNA	Delhi Private Nurses Association
DGHS	Directorate General of Health Services
EL	emergency leave
ESIS	Employees State Insurance Scheme
FGD	focused group discussion
GDA	general duty assistants
GNM	general nursing and midwifery
GNCTD	Government of National Capital Territory of Delhi
GCC	Gulf Cooperation Council
HOD	head of the department
HCW	health care workers
HIV	human immunodeficiency virus
HR	human resources
INC	Indian Nursing Council
IPNA	Indian Professional Nurses Association
IPC	infection prevention and control
IEC	information education communication
ICU	intensive care unit
ILO	International Labour Organization
JP Committee	Jagdish Prasad Committee
JCI	Joint Commission International
KI	key informants
MD	managing director
MSc	Master of Science
MLA	member of legislative assembly
MP	member of parliament

MWA	Minimum Wages Act
MoHFW	Ministry of Health & Family Welfare
NABH	National Accreditation Board for Hospitals and health care providers
NHRC	National Human Rights Commission
NSI	needle stick injury
NS	nurse superintendents
ND	nursing director
NRM	nursing resource management
OHS	occupational health and safety
OB	office bearers
OT	operation theatre
OECD	Organization for Economic Cooperation and Development
OPD	outpatient department
PPE	personal protective equipment
PDC	post-dated cheques
POSH	prevention of sexual harassment
PHC	primary health centres
PL	privilege leave
PF	provident fund
PHEIC	public health emergency of international concern
PHRS	Public Health Resource Society
QCI	Quality Council of India
RN	registered nurses
RTI	right to information
RCA	root cause analysis
SL	sick leave
SOP	standard operating procedures
SC	Supreme Court
SDG	Sustainable Development Goals
TNAI	Trained Nurses Association of India
UTs	union territories
UNA	United Nurses Association
UHC	universal health coverage
UTI	urinary tract infection
WHO	World Health Organization
WPSD	World Patient Safety Day
WP	writ petition

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Executive summary

Nurses and midwives form the backbone of health systems across the world and constitute the largest occupational group in the health care sector, accounting for almost 59% of the health professions. To highlight and focus on their contributions, their status, their work and working conditions, and the challenges they face as they provide vital clinical and health care, the year 2020 had been designated by WHO as the Year of the Nurse and the Midwife. As detailed in the State of the World's Nursing Report, nursing remains a highly gendered profession, with nearly 90% of the nursing workforce being female. Nurses in many countries, including India, face professional and social discrimination, gender bias and lack representation and leadership in policy making. Moreover, there is inadequate to poor regulation of their employment and working conditions. Since February 2020, the COVID-19 pandemic has aggravated these problems, and given rise to new challenges for them at their workplace.

Studies on nursing in India have largely examined distribution, composition and shortage of nurses for the health care services and how to address the gaps identified. They have also focused on migration of nurses from India, the caste-gender features in nursing and the hierarchies and discrimination against the nursing profession. In spite of policy recommendations and government orders to promote decent working conditions, there are no systematic studies exclusively focusing on the actual employment, work and working conditions of nurses in India, whether in public or private institutions. This, despite the fact that there are numerous references to the role of working conditions in influencing migration and in leading to occupational stress. While there is increasing participation of private sector in delivery of medical care in India, there is scarce documentation of the status of health care workers. Little is known about their working conditions, their perspectives and day-to-day experiences in the private sector. This exploratory study documents and analyzes the employment and working conditions of nurses in selected private hospitals in Delhi, along with relevant government provisions/legislation to regulate the same.

It is a case study, employing qualitative in-depth interviews (IDIs) and desk research for study of relevant documents and narrative literature review. Ethical approval for the study was taken from Institutional Ethics Committee of Public Health Resource Society (PHRS). Semi-structured interviews were conducted in English or Hindi, using a schedule of open-ended questions with nurses and key informants from among nursing association office bearers, and lawyers. Relevant information from an online event organized by this study group (PHRS, PSI, JSA and WHO India) on occupational safety and health (OSH) of nurses in India, on the occasion of the World Patient Safety Day (WPSD) on September 17th, has been also incorporated in this analysis.

The disruptions in the health care system in India in the face of the COVID-19 pandemic and the subsequent pressures on health care workers, particularly nurses, led to several challenges in recruiting nurse respondents. In all 31 nurses, 15 of them female, working or with experience of work in private hospitals, were interviewed. Interviews were recorded after obtaining consent, recordings were transcribed, translated and stored in the NVivo software provided by WHO-India Office, The data was subsequently coded and analyzed thematically.

The findings and discussion encapsulate the voices and perspectives of the nurses on important aspects of their work, such as, the recruitment process, remuneration, workload and nurse-patient ratio. They also focus on basic facilities at workplace and other employment benefits, such as medical insurance and maternity benefits.

The nurse respondents also shared their experiences of harassment, victimization and discrimination at workplace, occupational safety and health, gender dimensions and migration. Issues of Grievance redressal mechanisms, unionization, regulation of salary and working conditions, accreditation and its impact and experiences during COVID-19 were also mentioned by the respondents.

The study revealed an all-round failure of the private health care sector to acknowledge the nursing cadre as

health care professionals with a high level of training and experience. This is starkly reflected as inequities in recognition of nurses as clinically skilled professionals, the accompanying professional hierarchies, exploitation and failure to accord status and respect as trained professionals. An extremely low levels of remuneration is paid to nurses in private hospitals, low in absolute terms as well as in comparison to that in public sector hospitals. Salaries vary from less than US\$ 203 (₹15 000) for freshers to not more than US\$ 609 (₹45 000) even after more than 10 years of work experience. Even from these meagre salaries, sometimes deductions were made as penalties, such as for reporting late by few minutes or for loss of items from the ward.

Lack of job security and benefits

Another important finding is the lack of job security among nurses, irrespective of their skill, knowledge or work experience. Fixed-term contracts for a period not exceeding two years is the norm and very few nurses are recruited as regular/permanent employees. Only very senior positions, such as nursing supervisor or superintendents, are permanent. Very few nurses rise in the ranks of hospital management to wield any influence on decision making for both patients and nurses.

While the few who get into supervisory or management positions get better remuneration - over US\$ 676.68 (₹50 000 – the gap between them and a majority of the nurses in terms of remuneration as well as power remains extremely high. In fact, the nurses face a high level of job insecurity, as the current practice discourages upward mobility.

Experienced, senior nurses are replaced with freshers at lower salaries to protect the status quo of the existing hierarchy and to prevent escalation in running cost. Such fixed-term contracts deprive the nurses of their entitlements such as PF, increments, gratuity and also makes it easy for the management to fire them.

Working conditions

The study also sheds light on the poor nurse to patient ratios in private hospitals, at times being as low as 1:30 to cut costs, despite the impact of such poor staffing on patient care. The low nurse-patient ratio is further exacerbated by nurses being assigned non-clinical tasks such as maintaining records, managing efficient functioning of the ward and administrative work when patient is discharged. High patient load and such additional work hampers the actual task of delivery of quality patient care.

Alongside this situation of inadequate salary, lack of employment benefits and high workload, the study also finds disturbing evidence of insulting behavior, public humiliation and harassment, which are also ways of subjugating the nurses. These practices are in sharp contrast to the working conditions of doctors, senior nurses and management themselves. The difference in the working conditions is a sign of disrespect to the nursing cadre's contributions to patient care with the assumption that it is only the doctors that bring "money to the table".

Furthermore, lack of basic facilities at their workplaces such as clean washrooms, chairs, personal protective equipment (PPE) etc. makes them vulnerable to occupational hazards. The insecure working conditions have an adverse impact on their mental health. There is also discrimination against female as well as male nurses, even basic rights such as the right to form associations are denied to them. The low salary, poor working conditions and low social status and dignity were seen as contributing to migration of nurses. It was pointed out that improvement of conditions and more opportunities in the public sector would prevent nurses from leaving the country in search of livelihood.

Grievance redressal mechanisms are either non-existent or where available are not properly adhered to. The findings point to the positive impact of collectivization among nurses, giving them the confidence to take their problems to the management.

Further, it was only the persistent efforts of nurses through their unions, public campaigns and industrial action, that led to the petition in the Supreme Court of India (SC) in 2011. The landmark judgement in 2016 to legislate on salary and working conditions of nurses, led to government recommendations and order on

pay parity among the private sector and public sector nurses.

However, private hospitals do not want to have a union in the hospital as they perceive it as a threat and disruptive practice when nurses demand their rights. Formation of unions is actively discouraged by the management, as evidenced by the reluctance to hire male nurses who are seen as being more active in raising their voice as well as in organizing other nurses. There is also evidence of victimization of those who attempt to create awareness of and organize nurses for protecting their rights.

The issues of low salary, lack of job security, poor working conditions and occupational hazards and impact of all this on quality of patient care have been further aggravated during the COVID-19 pandemic. The study clearly documents the extreme challenges faced by nurses since the onset of the pandemic – from loss of jobs, non-payment of salaries to difficulties in commuting during the lockdown, working without adequate PPEs and training. The nurses have also been struggling through impossibly long hours without rest, food, water or even toilet breaks to facing discrimination at work. While one expects all health care personnel to put in extra effort in times like these, what emerges is the lack of support, care and appreciation that one would otherwise expect from the management. Instead, leave, quarantine facilities and due extra remuneration were all compromised, leaving nurses to fend for themselves and show up for work or be penalized, regardless of the circumstances.

The study also brings out the contribution of upstream factors in the nursing profession, such as the nature of nursing education, to the issues being faced by nurses in realizing their rights as employees. The lack of quality nursing education puts working in a ‘good hospital’ to gain experience at such a premium that many nurses compromise on remuneration in exchange. The nature of nursing education was also cited by many (especially female) respondents, as a reason for their failure to stand up for their rights, since there is a heavy stress on being dutiful and obedient.

The salary and working conditions of nurses appear to be better in corporate hospitals as compared to the small/non-corporate hospitals. The larger - especially corporate - hospitals seem to show greater adherence to laws, policies and regulations, than the smaller ones. Possibly, it is their relatively greater financial stability that allows them to do so.

However, they do not match the employment conditions prescribed for the public sector in terms of remuneration, career stability and growth and social security.

The study clearly reveals that they implement the bare minimum required to satisfy the law or regulation to maintain their image, rather than any genuine concerns for nurses’ rights or for parity within their own hierarchical structures.

It would be expected that regulatory mechanisms that have been set up to ensure quality of care would take care of at least those issues related to the working condition of nurses that pertain directly to patient care. However, the study throws light upon how these processes are circumvented by the management, presumably with the connivance of the regulatory authorities. Prescribed standards and conditions are observed only during the inspection for accreditation and diluted once it is over. The study also points to the reluctance and resistance among private hospitals to abide by court and government orders to improve the salary and working conditions of nurses, and finally to the lack of political will to enforce such orders.

In summary, the existing environment of a poor regulatory mechanism, in combination with the imperative to maximize profits by keeping costs for human resources (HR) down in a sector that is largely HR-dependent, is enabling a widespread neglect of the nursing cadre in the private sector in Delhi. It is hoped that this study contributes to firm action by the state to ensure long overdue reforms and regulations, an improvement in the employment and working conditions of nurses as it is also essential for the well-being of patients, as well as the entire health care sector.

Specific recommendations

1. The Centre and the state governments must immediately and strictly implement the JP Committee recommendations and initiate steps towards enacting legislation to regulate salary and working conditions of nurses. In doing so, policymakers need to subscribe to the recommendations laid down in the Decent Work theme of ILO, upheld by WHO for health care workers, the ILO Nursing Convention 149 and ILO Convention Number 155 - the Occupational Safety and Health Convention.
2. A statutory supervisory mechanism needs to be set up to ensure and monitor compliance on a regular basis. Accreditation should not be treated as a substitute for these statutory mechanisms.
3. Recognizing the fact that a high percentage of health care requirements are currently being taken care of by private sector, the government needs to explicitly acknowledge its regulatory role in ensuring that existing quality control frameworks, entitlements, schemes and laws apply to the private sector.
4. Formation of health workers' unions must be permitted as a matter of right and any discouragement needs to be curtailed proactively by the supervisory mechanism set up as recommended above. A unionized health workforce not only leads to a higher patient safety and better working conditions for health care workers, but also creates a robust public health system. There is ample evidence internationally that higher levels of union density led to better outcomes for both workers and patients.
5. Nurses must be directly represented, respectfully heard and formally made part of the decision-making process at their workplace and in public health policy-making.
Separate Nursing Directorate, nursing universities, and genuinely autonomous state nursing councils must be established in each state to facilitate authentic representation of nurses.
6. Nurse staffing norms in India must be revised in the light of international norms and research evidence available on actual workload of nurses, optimal nursing requirements for patient outcomes and quality of care. Nurse to patient ratios must be included in the oversight mechanisms enacted and strictly adhered to in health care facilities.
7. Considering that nurses are a permanent requirement for running any hospital, recruiting nurses on short-term contracts needs to be stopped and they must be included in the formal HR structure of the employing institutions.
8. Reforms and effective supervision structure need to be urgently established in nursing institutions to address the poor quality of education. Course content needs to be reformed to ensure that it is not only technical, but also empowers nurses with respect to public health issues as well as their own rights and duties.

The relationship between nursing education institutions and private hospitals needs to be rationalized to ensure that there is no automatic employment benefit to employers beyond the formal period of internship.

Capacity building of institutional heads, administrators, and managers of various health care institutions to reduce occupational hazards and improve safety standards within health care facilities need to be established and monitored as part of the regulatory framework. Dedicated occupational health care nurses should be appointed in the hospital for the support of their colleagues as well as the patient for a healthy work environment.

Although the National Policy on Safety, Health and Environment at Workplace 2009 and the Employees Compensation Act, 1923 (Schedule III, Part A) can be technically utilized by health care workers to demand their occupational safety and health related rights, the Government of India should declare COVID-19 as an occupational disease. In this regard the recommendations of the NHRC Expert Committee relating to health care workers should be widely disseminated and implemented by the concerned state authorities. The study reinforces the overall understanding that there is an inherent contradiction between profit-making in health care and enabling decent employment and working conditions for nurses. Conversely, it also suggests that goals of health care systems as well as concerns of

health care workers are better addressed through formally institutionalized, publicly financed, and publicly delivered systems. The study team recommends that the government develop an explicit road map for expanding and strengthening public health care services. Finally, civil society needs to prioritize advocacy on nurses' issues, especially for the enactment by states of comprehensive legislation as recommended by the JP Committee. This is essential to improve and regulate the employment and working conditions of nurses in private sector, including their occupational safety and health.

Section 1

1.1: Background

The WHO “Global Strategy on Human Resources for Health: Workforce 2030” draws attention to the importance of the human workforce in health to achieve the goals of universal health coverage and the Sustainable Development Goals (WHO 2016). The policy recommendations of this strategy include strengthening of data on health workforce, promotion of decent work and employment conditions, regulatory mechanisms to promote patient safety and an adequate supervision of the private sector. Decent Work and Employment Conditions adopted should be as specified by ILO. They should include opportunities for work that are productive and deliver a fair income and job security in the workplace and social protection for their families. It should allow freedom for people to express their concerns, organize and participate in the decisions that affect their lives, offer better prospects for personal development and equal opportunity and treatment for all women and men¹.

The WHO strategy further specifies that the decent work and employment strategies should include measures for job security, a manageable workload, supportive supervision and management, continuing education and professional development opportunities and enhanced career development pathways. They should include hardship allowances, housing and education allowances, adequate facilities and working tools and measures to improve occupational health and safety and a working environment free from violence, discrimination and harassment (p 18).

It recommends that ministries of health and employers should cooperate to ensure occupational health and safety, fair terms, merit-based career development opportunities and a positive practice environment. This would provide them adequate motivation to deliver quality care and build a positive relationship with their patients. Gender-based discrimination, violence and harassment during training, recruitment/ employment and in the workplace should be eliminated (ibid p 17).

The WHO strategy calls for states to formulate long-term (10–15 years) public policy to invest in decent conditions of employment that respect the rights of male and female workers, promote better working environments, stimulate personal growth and include the provision of a living wage (including for community-based health workers). The policy should also envisage incentives for equitable deployment and retention, in line with the SDG Goal on “Decent work and economic growth”.

It should also take measures to eliminate stigma and discrimination by and towards health workers (ibid p 25).

Nurses and midwives form the backbone of health systems across the world, providing the prescribed clinical treatment and preventive, promotive, primary care services in the community. They constitute the largest occupational group in the health care sector, accounting for almost 59% of the health professionals (WHO 2020). As detailed in the State of the World’s Nursing Report, nursing remains a highly gendered profession, with nearly 90% of the nursing workforce being female. Yet, nurses in many countries, including India, face professional and social discrimination and gender bias. They lack representation and leadership in policy making and inadequate to poor regulation of employment and working conditions

¹<http://www.ilo.org/global/topics/decent-work/lang--en/index.htm>

(WHO 2020). The year 2020 was designated by the WHO as the Year of Nurses and Mid-wives, to focus on the contribution and status of nurses, their work and working conditions and the issues and challenges they face.

As the president of the International Council of Nurses said, at the start of the Year of the Nurse and the Midwife, “Whenever I talk to nurses, I realise that each of them has a story to tell. They are with patients from birth to death, they share in their saddest and most joyful moments, they help them to get through the most traumatic of situations and they help them to recover their lives. In 2020, we need nurses to share their stories, to tell their families, their friends and the communities that they live in what it is like to be a nurse, the pressures they are under, the challenges they face and the triumphs they witness” (Kennedy 2019).

The year 2020 also began with the rapid spread globally of the coronavirus disease (COVID-19), caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which began in December 2019 in Wuhan, China. On 30 January 2020, WHO declared that COVID-19 outbreak was a public health emergency of international concern (PHEIC). It recommended that all countries should be prepared for containment, including active surveillance, early detection, isolation and case management. Contact tracing was also essential for prevention of spread of the virus. The pandemic has put a severe strain on health systems and the health care workers in most countries, including India. Efforts to control it through measures such as lockdowns have led to unprecedented disruptions in lives and livelihoods of populations globally. It also brought into sharp focus the important role of nurses, as well as their work conditions and the huge risks they faced while performing their tasks. On 3 March 2020, WHO warned that severe and mounting disruption to the global supply of PPE kits - caused by rising demand, panic buying, hoarding and misuse - was leading to severe shortages. This left doctors, nurses and other frontline workers dangerously ill-equipped to care for COVID-19 patients.

The shortages of essential PPE such as gloves, medical masks, respirators, goggles, face shields, gowns, and aprons were posing a threat to both health workers and patients. “Without secure supply chains, the risk to health care workers around the world is real. Industry and governments must act quickly to boost supply, ease export restrictions and put measures in place to stop speculation and hoarding. We can't stop COVID-19 without protecting health workers first,” said WHO Director-General Dr Tedros Adhanom Ghebreyesus².

In India, health care workers, including nurses, started facing a variety of occupational health and safety issues especially in the early stages of the COVID-19 pandemic, apart from increased exposure to the pathogen. A country-wide, total lockdown was imposed by the government on 23 March 2020, initially for a month and subsequently extended several times until 31 May 2020. A major objective of the lockdown was to contain the corona virus to a manageable level through physical distancing and to use the time to prepare the country's health care system to cope with the projected exponential surge in cases. Following a call by the prime minister, asking citizens to applaud the efforts of health care workers (HCWs), associations of doctors and nurses from across the country began to publicly report about the difficulties they were facing in the hospitals, such as severe shortages and poor quality of PPE and the risky conditions of work at hospitals in the pandemic. They also faced issues of lack of proper quarantine facilities, long hours of work, lack of rest, lack of transportation, and other adverse impacts on working conditions.

1.2: Literature review

1.2.1: Size, composition, distribution and nursing education

Till date reliable, comprehensive, updated data on the health workforce, including that on nurses, remains weak in India. This is primarily due to factors such as, multiple sources providing estimates using non-comparable methods for data collection, professional registries such as those of Indian Nursing Council

²<https://www.who.int/news/item/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide>

(INC) not being updated regularly (lack of live registries), as discussed at length by Gill (2016). Available information indicates that qualified female health workers constituted almost half of the qualified health workforce. As of 2020, government reported 3.07 million registered nursing personnel (India Spend team 2020). Nurses constituted 35% of the total health personnel in the country, forming the largest segment (Rao et al 2009). The category of qualified nurses and midwives was dominated by women to the extent of 88.9% and 48.8% of nurses and mid-wives in rural and 59.8% of those in urban areas were privately engaged (Rao et al 2016).

In 2010, a shortage of 2.4 million nurses was reported in the country. While WHO norm is three nurses per 1000 population, India's ratio was 1.7 per 1000, which includes nurses, midwives, women health visitors and auxiliary nurse midwives (ANMs) – (WHO 2010). The shortage of nurses is not simply a matter of absolute numbers, it also needs to be viewed in the light of multiple phenomena such as preference for employment in the urban areas, inadequate sanctioned posts in the public sectors and non-replacement of the staff retirements over long periods of time. Moreover, low salary, poor working conditions, low status and professional social discrimination are some of the other factors that impact International migration of the nursing workforce. (Gill 2016).

With declining number of public nursing colleges, the private sector has gradually become the dominant provider of nursing education in India. At the national level, the number of institutions offering Bachelor of Science (BSc) (Nursing) increased from 349 in 2005 to 1 831 in 2016. Master of Science (MSc) degree institutions increased from 54 to 637 over the same period and diploma colleges also increased, institutions offering auxiliary nursing and midwifery qualifications rose from 254 to 1 986 and those providing general nursing and midwifery qualifications rose from 979 to 3 123 between 2005 and 2016 (Indian Nursing Council data cited in WHO 2017). At present 88% nursing schools are in private sector, which produces 95% of nursing professionals and of the nursing colleges offering courses in general nursing midwifery, 88% were private sector institutions.

The heterogeneity that characterizes private health care provision in India, is prevalent also in private nursing education, which comprises a range of institutions from recognized to unrecognized nursing colleges and training centres. Then there are private corporate hospitals with nursing colleges which offer specialized courses and train nurses for employment abroad. The private institutes charge a higher course fee, but 61% of them were found unsuitable for training nurses, with poor quality of training, inadequate infrastructure and lack of qualified faculty (Rao et al 2011). Consequently, a section of nursing students graduated with the burden of educational loan and without adequate hands-on training. The review by Rao et al (2011) found that such nurses had low employability, took underpaid jobs, underwent skill training in hospitals as intern or post-graduate training. The array of private health care providers adds another dimension to the issue of qualified nurses and nursing training - small to medium private hospitals are known to hire local young persons as nurses and train them on the job for a short period or employ ANMs, or nurses trained in private institutes unrecognized by INC (Gill 2016). There are also those trained by doctors in their hospitals, or supplied by unrecognized informal training centres (Basu 2019).

The entire nursing workforce, therefore, consists of a mix of persons with different levels of education and training, such as qualified registered nurses (RNs) and unqualified nurses. Unqualified nurses and midwives account for 58.4% of the workforce, which means they did not possess the necessary qualification for their cadre (Rao et al 2016). Low employment opportunities in public sector make private hospitals the only employment option for also the trained RNs³. This poorly regulated nursing education scenario is exploited by small and big private health care providers and they do not pay adequate wages to

³Qualified Nurses have either a diploma in general nursing and midwifery (GNM), or a bachelor's degree in nursing, or a postgraduate degree, and registered with the Indian Nursing Council (INC). ANMs, who mainly work as subordinates to the main nurse, have a diploma in auxiliary nurse midwifery. GNMs are the most common in India, serving in a range of public and private health facilities, ranging from PHCs to tertiary hospitals. Nurses with a bachelor's degree and above constitute a smaller proportion of the nursing workforce (WHO 2017). There are also community health workers with ten years of formal education and have undergone a short training course.

even the qualified, registered nurses (Nair 2010).

1.2.2: Low professional status, professional and social discrimination

Studies have examined the prevalence of professional hierarchies in the health care sector and discrimination by medical professionals, intersecting with patriarchy-caste-religion, leading to an unjust, unequal, and exploitative relationship between doctors and nurses on one hand, and low professional status of nursing on the other. Mayra (2020) describes the humiliation, disrespect, and even sexual harassment meted out by sections of the medical community to nurses and mid-wives, and the lack of nurses in administrative and policy-making processes. For instance, nursing councils in India are managed by medical and health-service personnel, which means that nursing staff have difficulty exercising their authority and leadership because the nurse's role is subordinate to the roles of the clinical and public health personnel (Rao et al, 2011). However, it has also been pointed out that both male and female nurses face gender bias, discrimination and exploitation. For example, on one hand discrimination based on gender constricts the participation of women in leadership positions, on the other hand it restrains men entering into nursing profession (Tankha, 2006, WHO 2019).

As nursing involves providing personal services and exposure to the bodies of other people, which is looked upon as polluting in the caste system, it is not held in high esteem by upper caste people who therefore do not opt for nursing profession. Overall, nurses in India face gender and caste-based occupational segregation, lack of decent work (Nair, 2012; Seth, 2017), low participation in leadership role (Biju, 2013), violence and harassment (Gill 2016, Chaudhuri, 2007, Nair, 2016).

A review on human resources for universal health coverage (UHC) in India noted that despite efforts by the government to standardize nursing education and increase training capacity, the nursing profession continues to be of low status and neglected within the country, even though Indian nurses are much sought after abroad. The reasons for this are factors such as focus on medical education, substantial political influence of the medical community and poor health financing by the government. (Rao et al 2011).

1.2.3: Work conditions – wages, occupational safety and health, contract employment

The low professional status of nursing along with the gender-caste composition of nursing workforce has consequences for the working conditions of nurses.

In 1989 the High Power Committee on Nursing and Nursing Profession, constituted by the government mentioned long working hours, inadequate work place (duty stations), lack of supplies and equipment, forced working on non-nursing duties among the problems faced by the nurses in India (Government of India 1989). The conditions of nurses have not changed very much over the three decades since this committee reported on the dismal state of nurses. A government-appointed committee in 2016 observed that adequate salary and basic facilities were not being provided to nurses in private hospitals and nursing homes and that their condition was pathetic. It recommended that steps need to be taken to raise the standard and put them at par with government employed nurses, as well as to formulate appropriate legislation to improve the working conditions in private hospitals (committee report 2016) (Discussed further in I.2.6 and Section 4). There is wide variation in the wages of nurses across different types of hospitals, with nurses in private health sector paid significantly less than similarly qualified nurses in public health facilities (Seth 2017, Walton-Roberts et al 2017). There are sections of nurses who are not even getting minimum wages (Nair 2010). Nurses in the private sector struggle with low incomes that are not adequate to support a decent life, with work stress and commuting challenges leading to poor work life balance (Taware & Patil, 2018). However, in the public sector too, while permanent nursing staff may have better conditions of employment, there is a gradual move towards contract employment and dilution of their existing entitlement. This is leading to gradual shift in the work culture of even public hospitals (Roy, 2018).

Nurse-patient ratio is an important element in hospitals, affecting workload of nurses and patient outcomes. A recent review of nurse-patient ratio and nurse staff norms in India revealed the following:

- Nurse staffing norms in India have not been updated since a long time and they are far behind international norms and estimated ratios in some of the research studies conducted in India.
- The estimations of the nurse-to-patient ratios are primarily done based on the projected workload of nurses for direct patient care, whereas nurses are involved in various indirect care activities, such as documentation, communication, meetings, rounds, reporting, administrative and other logistics-related activities, which are generally not taken into consideration while estimating nurse-to-patient ratio.
- There is need for workload-analysis based research evidence to have true nurse-patient ratio.
- Recommendations by National Accreditation Board for Hospitals and Health care providers (NABH) are the most recent and realistic as well as feasible to use in India (Sharma and Rani 2020). This review concludes that nurse staffing norms in India must be immediately revised in the light of international norms and research evidence available on actual workloads, optimal nursing requirements for patient outcomes and quality of care.

Hazards at workplace such as needle pricks, hospital acquired infections, exposure to radiation, stress, violence are common, (Chhabra, 2016). Violence-physical, mental and sexual abuse – against nurses is not uncommon and is often inflicted by the patient's relatives, colleagues or even superiors (Chaudhuri, 2007; Mishra et al., 2018; Nair, 2016). Studies on occupational health of nurses reveal that the nurses are not well-equipped for prevention of and response to occupational injury, most common being the needle stick injury (Lal et al., 2017; Shinde et al., 2015). Such injuries have immediate as well as long-term implication on health of nurses (Anap et al., 2013; Nayak et al., 2016).

Nurses employed in the private sector on fixed-term contracts were constantly worried about their job security (Kar & Suar, 2014). Studies from other countries indicate that work and nature of the work environment, which vary across institutional settings, are key factors in issues of nurse shortage and retention (Aeschbacher and Addor 2018).

1.2.4: Migration

International migration of trained nurses from India has received much attention. India is considered the second largest exporter of nurses after the Philippines, with an estimated 640 078 Indian nurses migrating abroad in 2011 (Oda et al 2018). These authors note that large-scale international migration of nurses began with rapid increase in nursing educational institutions in the country, largely private ones. Their study among nurses in Tamil Nadu indicated that nurses graduating from private schools were more likely to migrate out than those from government schools (ibid.). Nurses who emigrated were better qualified and had more experience, resulting in a shortage of competent nursing staff in hospitals (Rao et al 2011).

Low remuneration and poor working conditions in India were the most important factors for nurses choosing to emigrate (Garner et al 2015), pointing to the need to improve working conditions and professional development of nurses (Rao et al 2011). A study by Johnson et al (2015) of the careers of nurses in Bengaluru, India, highlights positive implications of migration for the workforce remaining in India, including those from non-Keralite communities. The study said it facilitates the collective social mobility of Indian nurses. The fact that nurses can secure jobs abroad has been a key factor in changing the image of nursing not just for those who migrate, but even for those who remain. Almost all nurses interviewed in their study who intended seeking overseas employment envisaged migration as a short-term option to satisfy career objectives – increased knowledge, skills and economic rewards - that could result in long-term professional and social status gains 'back home' in India. For others, migration was not part of their career plan, yet the increase in status that migration possibilities had brought were crucial in choice of nursing as a suitable job' for a growing number of entrants”.

According to a study on migration of nurses from Kerala (WHO 2017), there is a decline in nurses from Kerala migrating abroad as indicated by household surveys that showed a decline in the migration rate from 32.8% in 2011 to 30.8% in 2013 and to 23.2% in 2016. Nearly 57% of all emigrant nurses resided in Gulf

countries (Saudi Arabia being the most favoured) in 2016. However, challenges in getting visas and citizenship for the spouse and offspring are seen as possibly contributing to reduction in emigration of nurses over the years. It appears that the desire to “settle” and “be stable” outweighed career-related considerations for nurses from India and the Philippines working in Ireland (cited in WHO 2017). Biju (2013) attributes the decrease in international migration to barring of diploma holders by Organization for Economic Cooperation and Development (OECD) countries and the global economic crisis leading to return of migrants from the Gulf countries.

A significant number of nurses from Kerala also migrated to other parts of India. However, these numbers are much lower than the number of nurses migrating overseas, pointing to the much stronger appeal of working overseas. The major states preferred by nurses for migration within India in 2016 were: New Delhi (57.2%), followed by Rajasthan (28.7%) and Maharashtra (14.1%). The number of nurse or nurse assistant migrants increased from 6 564 in 2011 to 7 662 in 2013 and declined to 3 862 in 2016. (WHO 2017).

The decrease in national migration is attributed to the increasing competition in the national labour market, declining wages, worsening service conditions and increasing cost of living (Biju 2013).

1.2.5: Collectivization in nursing

Over the past decades, nurses have begun to collectivize for better employment and work conditions, leading to various nursing association and unions, followed by strikes, protest marches and petitions, demanding their rights as employees (Roy, 2018; Nair & Healey, 2006). Organizations emerged among nurses after 2010 in Kerala, Delhi, Mumbai, such as Indian Professional Nurses Association, United Nurses Association, Delhi Professional Nurses Association and took up the problems faced by nurses in private hospitals, through strikes and petitions to the government. Traditional associations such as the Trained Nurses Association of India also could not ignore the movement among the nurses and the pressures by its own members to take up the cause of their working conditions in private hospitals.

In April 2018 a strike by 370 nurses, organized by the United Nurses Association, at Maharaja Agrasen Hospital in Delhi was successful in getting for the nurses better pay, along with better work conditions and nurse-patient ratios⁴. In November 2018, over 350 nurses at Batra Hospital went on strike to demand better working conditions as per NABH norms, maintaining of nurse-patient ratio and minimum wages as per Supreme Court recommendations. They also demanded implementation of the maternity leave policy, Employees State Insurance (ESI), insurance coverage, and annual increments and bonuses and a halt to sexual discrimination (DNA Correspondent 2018). In 2017-18 nurses of private hospitals in Kerala too launched a prolonged struggle for basic demands, such as wages of US\$ 155.63 (₹11500) and proper 8-hour shifts (PSI 2018).

In a discussion on the strikes by nurses in several private hospitals in Delhi during 2009-10, Nair (2010) identifies the 'overwhelming disparity' in the working conditions and salary between public and private hospitals as an important factor that led to nurses working in the private sector collectively organizing themselves. The salary then for a fresh nurse in a government hospital was in the basic pay scale of US\$ 74 (₹5500), whereas the total salary in a private hospital then was US\$ 34-81 (₹2500-6000). The announcement of the Sixth Pay Commission for government employees increased this disparity drastically and became a trigger for the spate of strikes then. In this context, Nair points to some of the challenges for nurses in collective organizing for their rights, such as nursing being seen as an essential service that constrains unionization, the gendered nature of the work and pre-dominance of women in the profession and negligent attitude towards the problems of nurses by traditional trade unions.

Apart from these, there is a growing hierarchy within nursing education - a by-product of professionalization - which is creating divisions among nurses, and preventing collective bargaining. In some cases there is complicity of nurses themselves in not organizing themselves for their rights, but finding escape routes such as migration.

⁴<https://www.world-psi.org/en/striking-nurses-win-delhi-india>

Biju (2013) in his discussion on the formation of politically independent unions by private hospital nurses in Kerala and their successful strikes in 2012, views the developments as a sign of class-formation and of 'politically ignored' labour unrest in the hospital industry. He also focuses on the emergence of nurses' organizations like the United Nurses Association, Indian Professional Nurses Association and approach of political parties and the state government towards the unionization.

According to Biju, changes in gender and religious composition of the workforce also helped the process of trade unionization: the increase in non-Christian nurses weakened the hold of religion and its view of nursing as a noble service in the workplace and the recruitment of large number of male nurses, who initiated formation of labour unions in hospitals. Biju points to the 'inadequate and dithering presence of women' in leadership roles in the union, despite their massive participation in agitations. He explains this by reasons such as familial constraints, disappointment with the quarrels among the male leaders of different unions and decline in interest after the announcement of the model wage package by the government.

1.2.6: Regulation of employment and working conditions of nurses

International Labour Organization instruments that set the standards for employment and working conditions in nursing in both public and private sector are the Nursing Personnel Convention 149⁵ and Nursing Personnel Recommendation 157⁶. While Convention 149 is short and sparse, Recommendation 157 contains noteworthy principles, such as a fair remuneration commensurate with duties and responsibilities and no discrimination between working conditions in public and private sector. It includes, but not limited to, wages and hours of work regulated as for other workers - which in India is 8 hours - with overtime pay for extra hours. The Government of India has not yet ratified these instruments.

India had an extensive set of labour laws that cover most aspects of workers' rights in their workplace with their employer and in relation to collectivization. In India's federal system, labour is a concurrent subject that can be legislated upon by the central government as well as the state government.

Over the past few years, 44 central labour laws have been merged into four Codes: the Code on Wages 2019, the Code on Industrial Relations 2020⁷, the Code on Social Security 2020, and the Code on Occupational Safety, Health and Working Conditions 2020⁷. The codes and the rules created by the central government can be amended when enacted at the State level.

Before the codification, nurses were deemed covered by labour laws as they were not explicitly excluded under them. Hence important labour legislations such as the Trade Unions Act 1926, the Minimum Wages Act 1948, as well as the Delhi Shops and Establishments Act, 1954, to name a few, regulate the rights of nurses in the private health sector in Delhi with regard to their employment and work conditions. The minimum wage for skilled workers in Delhi in October 2020 was fixed at US\$ 243 (₹17 990) per month and paying a nurse below this would amount to violation of this law⁸. Nurses in the private sector are entitled to social protection such as health insurance or ESI - for nurses with a salary of up to US\$ 284 (₹21 000) per month - PF for pension and maternity benefits⁹. If employed for over five years in facilities with at least 10 employees, nurses should get gratuity at the time of leaving a company. Nurses are also entitled to other benefits such as annual bonus if working in health facilities with at least 20 employees or earning

It is to be noted that on a petition by a nurses association in 2016, in a judgement, the Supreme Court observed that the nurses working in private hospitals and nursing homes are not being treated fairly in the

⁵ https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C149

⁶ https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312495

⁷ Some central labour laws have not been brought under the ambit of the codes and remain untouched, such as the Sexual Harassment Act.

⁸ For more details on the process of wage increase in the state of delhi, see, <https://www.newsclick.in/Delhi-Govt-Delays-Minimum-Wage-Hike-Workers-Financially-Struggle>

⁹ Refer to the Employees' State Insurance Act 1948, Employees' Provident Funds Act 1952, The Maternity Benefit Act 1961, The Payment of Gratuity Act 1972, Payment of Bonus Act 1965.

matter of their service conditions and pay, and ordered the Central government to do the needful for improvement of their working conditions, including legislation by the states or by the central government itself (See also Section 4.2 for more discussion on this).

Box 1.1: Pay, not simply minimum wage for nurses

The issue of minimum wage needs to be interpreted keeping the context in mind in the case of nurses, as clarified by the courts. In analyzing the orders of the 2016 Supreme Court order, the Delhi High Court in 2018 pointed to the use of the term 'salary' and not 'minimum wage' by the SC, and the difference between the two and its significance therefore to the working conditions of nurses: "It is of prime importance in this context to note that the Supreme Court, in its order dated 29 January 2016 in Trained Nurses Association of India (supra), did not use the word "minimum wage". Instead, the word used, in the said order, is "pay". There is a fundamental difference between "pay", and "minimum wage", though undeniably minimum wages are also "pay". R. S. Nayak v. A. R. Antulay, (1984) SCC 183 defines "pay" as meaning "salary, compensation, wages or any amount of money paid to the person who is described as in the pay of the payer". In State Bank of India v. K. P. Subbaiah, (2003) 11 SCC 646, the Supreme Court held that the word pay, in its ordinary significance in relation to service, meant "to give what is due for services done". Needless to say, the expression "what is due" would encompass, in almost every case, more than the minimum wage applicable to the post in question. The Supreme Court too in its order in Trained Nurses Association of India (supra) has parenthesized together, "service conditions and pay". These two expressions, therefore, would merit interpretation noscitur a sociis (immediate context rule). "Service conditions" refers to the conditions attending the service performed by the employee concerned. These "conditions" again obviously would include an entitlement to the salary applicable to the post, and not merely to minimum wages under the Minimum Wages Act.

(from Judgement of the Delhi High Court in Association of Health care Providers of India versus Government of NCT of Delhi, July 2019, downloaded from Indian Kanoon - <http://indiankanoon.org/doc/152416598/>)

Until 2011, many hospitals practiced a form of 'bonded labour'. They would withhold the certificates of fresh recruits as a guarantee that they would not leave for a certain period after joining. If they wished to leave, they would have to pay a fixed amount of US\$ 2 707-4060 (₹2-3 lakh) to get back their certificates.

Following the suicide by a nurse in a Mumbai hospital in August 2011¹⁰ (Staff Reporter 2011), the Trained Nurses Association of India (TNAI) filed a petition in the Supreme Court on the abysmal wages and working conditions, and the bond system in the private health care sector in the country.

In 2016 the Supreme Court passed its judgement directing the central government to form a committee to look into the grievances described in the TNAI petition and make appropriate recommendations. This judgement further noted that the Indian Nursing Council (INC) had abolished the bond system in August 2011, hence the grievance does not survive. The Jagdish Prasad Committee appointed by the Ministry of Health and Family Welfare (MoHFW) in this regard made the following recommendations:

- For hospitals with more than 200 beds, salaries should be at par with that in state government facilities for the corresponding grade. For facilities with more than 100 beds, salary should not be more than 10% less in comparison to state government facilities. For hospitals with more than 50 beds, salaries should not be more than 25% less compared to state facilities. Salaries of private nurses should not be less than US\$ 270.6 (₹20 000) in any case, even for hospitals with less than 50 beds, which is over US\$ 27 (₹2000) more than the current minimum wage that applies to private sector nurses.

¹⁰ <http://www.ilo.org/global/topics/decent-work/lang--en/index.htm>

- Working conditions such as leave, working hours, medical facilities, transportation, accommodation, should be at par with the benefits granted in government facilities.
- Steps should be taken by all states/UTs for formulating legislation/guidelines to be adopted for implementation of the above recommendations in case of nurses working in private hospitals/institutions.

In June 2018, the Government of National Capital Territory of Delhi (GNCTD) issued an order to private hospitals to abide by the recommendations of the 2016 JP Committee. In a challenge to this order, the Delhi High Court upheld this order. However, no action has been taken against hospitals violating the order (discussed at length in Section 4).

Despite the importance of the nursing workforce for the health care sector, the recommendations of international bodies such as WHO and ILO for ensuring decent work and employment conditions for nurses and also recommendations by the courts and government committees, till date there are no central or state legislations specifically regulating the employment and working condition of nurses.

1.2.6: Accreditation

Since the 1990s accreditation has been promoted by the corporate hospitals in India as the way to standardize and improve patient safety and quality.

Accreditation has been defined as “A self-assessment and external peer - assessment process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system” (NABH 2020 p 98). In 2005, the National Accreditation Board for Hospitals and Health care Providers (NABH), a constituent board of Quality Council of India (QCI), was set up to establish and operate accreditation programme for health care institutions in India. NABH standards focus on patient safety and quality of the services of the hospitals. Since 2009, central and state governments have mandated NABH accreditation as a prerequisite for empanelment under government health insurance schemes; private insurance schemes also often require NABH accreditation. NABH has laid down standards guiding hospital operations through patient-centered and organization-centered standards, which entail specific objectives covering clinical operation and governance through clear policies and protocols of the hospital (NABH 2020). The accreditation is an ongoing process and needs to be renewed after three years. NABH conducts surveillance audits at frequent interval to monitor the operations of the hospital for adherence to the NABH standards and observe their policies and procedures.

NABH also offers a Nursing Excellence Certification and has laid down standards for nursing excellence (NABH 2013), aimed at promoting safe and ethical nursing care. Like accreditation, this certification is also voluntary. The hospital can apply to NABH for this certification, which entails assessment by NABH of the hospital's nursing functions and services. The hospital is required to take necessary corrective action to any non-conformities identified to get the certification. The certificate is valid for two years, and hospitals may apply for renewal of certification at least 6 months before the date of expiry.

Several of the NABH standards have a direct impact on the working conditions of nursing professionals such as, hospital infection control, patient safety and quality improvement, facility management and safety, and human resource management. For instance, the NABH standard prescribes nurse-patient ratios for different departments; hospital has to take action to prevent health care associated infections in its staff through occupational health and safety practices. The hospitals need to have an immunization policy for staff and also endeavour to promote a culture of reporting safety related issues so that there is no victimization. (NABH 2020).

The Nursing Excellence Standards for nursing resource management lay down a detailed set of seven standards for acquiring, retaining and maintaining the nurse resource. The standards cover practices such as, established process for appropriate management (nurse resource planning/appropriate number of nurses maintained as per the workload and nurse-patient ratio as per scope of unit.

The standards focus on all the critical issues related to the nursing profession, including induction training, in-service education and nursing education programme, autonomy to provide unsupervised care through 'credentialing and privileging' nurses and appraisal, evaluation and acknowledgement of performance. Safety and protection of nurses - identifying and handling issues of competency/safety /misconduct, safety at workplace, system to ensure infection control and hazard prevention, and system for grievance management- is also part of the Nursing Excellence Standards.

The NABH guidelines place accountability on hospitals/institutions to take necessary steps to ensure safety of nurses such as providing resources related to safety at workplace. The hospital managements need to provide sufficient facility of changing, washroom and dining space; appropriate mechanism for reporting safety-related issues, including establishment of a committee for safety against sexual/gender harassment, to have an established system for grievance redressal. Nursing professionals also must be educated about their rights. The NABH also set standards for empowerment and governance which clearly defines the need for a system within the institution to- enhance leadership skill of nurses and to ensure their participation in various committees such as grievance, infection control, etc.

While accreditation is not mandatory and the NABH standards do not directly address concerns of salary and social security of the nurses, the standards if adhered to have some scope for improving working conditions. If implemented, NABH standards can influence factors such as number of nurses as per workload, patient-nurse ratio, division of work, scope of nursing services, providing resources related to safety at workplace, enabling grievance redressal and participation in decision-making .

Available studies of impact of NABH accreditation show that hospitals do not sustain the standards post-accreditation. This makes bringing about tangible change in working conditions difficult. One study of a 285-bedded NABH accredited hospital, with five ICUs and four recovery rooms, conducted in 2012-13 after almost five years since it got accreditation, showed that standard procedures were not followed in the hospital post-accreditation (Tadia et al 2017).

Analysis of NABH indicators also showed that most indicators varied greatly from the benchmark decided by the hospital; incidence of NSI was very high from the benchmark set for the hospital; management showed a positive attitude towards NABH accreditation and recognised its importance, but was unable to maintain the standards. Lack of awareness of staff regarding standard operating procedures (SOPs), lack of motivation to follow SOPs, excess workload, and shortage of staff in ICUs, high attrition rate in ICUs were among the reasons cited by hospital for non-compliance.

In another study on effects of accreditation on nurses, the latter reported increased work stress and clerical work following NABH standards implementation, while there was a more streamlined work pattern and improvement in working conditions (Indumathy and Ravichandran 2017).

Section 2

2.1: Rationale and objectives

Studies on nursing in India have largely examined distribution, composition, and shortage of nurses for the health care services and how to address the gaps identified. There are also studies that focus on migration of nurses from India, the caste-gender features in nursing and the hierarchies and discrimination against nursing profession. Despite policy recommendations to promote decent working conditions and references to role of working conditions in studies on migration and occupational stress, there are no systematic studies exclusively on the actual employment work and working conditions, whether in public or in private institutions. What is missing is the perspective and voices of the nurses themselves on the issues that are most critical to them about their employment in the health care sector, especially in private hospitals. The objective of this study is to understand their most important issues through lived experiences at work and their perspectives on issues such as migration and collectivization.

The conditions of employment and work for nursing professionals within the private sector are anecdotally far worse and largely invisible. While it is widely known that the private health care sector is dominant in India and there is an increasing participation of private sector in delivery of medical care through several government health insurance schemes, there is scant documentation of the status of health care workers in private hospitals and their day-to-day experiences.

The present study is an attempt to fill this gap in existing knowledge. This exploratory study documents and analyzes the employment and working conditions of nurses in selected private hospitals in Delhi, and relevant government provisions/legislation to improve, safeguard and regulate these conditions.

The specific objectives :

- To document in detail the existing employment and working conditions of nurses in selected private hospitals in Delhi.
- To identify/document relevant norms, provisions and legislations to regulate employment and working conditions of nurses
- To study the existing state of implementation of existing provisions so identified
- To highlight institutional/organizational arrangements facilitating effective implementation of the provisions.

When the study was conceptualized and initiated in February 2020 the ongoing COVID-19 pandemic had not yet taken epidemic proportions in India, nor was its enormity acknowledged then, despite WHO declaring it as a Public Health Emergency of International Concern (PHEIC) on 30th January 2020. The subsequent course of the epidemic in the country thrust into the public domain the extremely difficult working conditions of health care workers and the serious occupational risks they faced. Hence, documenting the experiences of nurses while providing medical care during the COVID-19 pandemic further highlighted the dismal working conditions of the nursing community.

Ethical approval

Ethical approval for the study was taken from Institutional Ethics Committee of Public Health Resource Society (PHRS).

2.2: Methodology

The study is primarily a qualitative case study, comprising qualitative in-depth interviews, and desk research for study of relevant documents and narrative literature review.

In-depth interviews and discussions were scheduled to be held with nurses and key informants as described below.

Respondents

- Nurses from private hospitals in Delhi purposely selected for variation [in size and status as not-for-profit (trust) or for-profit] - approximately 30 from different hospitals and different categories/ different seniority levels. A list of 16 hospitals was drawn up, where contacts were available and hence interviews with nurses could be arranged. There were four hospitals each in the following size categories: less than 50 beds, 51-100 beds, 101-200 beds and above 200 beds. Two nurses from each of these were to be interviewed - one with less than five years work experience and a senior nurse with more than five years' experience.
- Hospital managers/administrators of above hospitals (about four)
- Representatives/office-bearers of nursing organizations (about four)
- Representatives/office-bearers of hospital owners association (about two)

Total number of respondents: Approximately 40 (32 nurses and about 10 others, as mentioned above)

We anticipated that this would be the number required to keep the sample representative as well as to reach saturation in information.

Sampling method was to be a combination of Purposive and Snowball/Chain Sampling - respondents were to be initially based on known contacts and subsequently, through snowball/chain sampling. Sampling was to also be flexible to an extent to make use of opportunities that may arise after the interviews are initiated - persons other than those listed above may be interviewed. If required focused group discussions (FGDs) would be conducted with nurses.

Interviews

Semi-structured interviews were conducted in English or Hindi, using a schedule of open-ended questions. They covered topics such as process of recruitment, salary, and other employment benefits such as Provident Fund, Medical Insurance, maternity entitlements; provisions for safety at work, availability of leave, facilities such as creches, restrooms, problems faced at work and grievance redressal mechanisms and forms of collectivization. The tools used are provided in Annexure 1.

A master list of potential respondents for the study was created and persons on this list were contacted by the study group members. The aims of the research and the purpose of the interview were explained to the potential respondents and they were invited to participate in the research at a time convenient to them. At the time of the interview, respondents were informed about how the data they provided would be used, asked to complete a consent form and informed that they could withdraw their responses from the study at any time up until the end of the data collection period. An information sheet and informed consent form respectively were also prepared and mailed to the respondents. These documents are provided in Annexure 2.

The interviews were audio-recorded after informing the respondents and taking their consent. Five interviews were done face-to-face; one participant refused a discussion but consented to provide responses in writing; the FGD was conducted at a hospital site; remaining 15 interviews were either online or telephonic. All the interviews were conducted by Ipsha Chaand and Indira Chakravarthi; they were joined by Susana Barria in four interviews and the FGD.

Relevant information from an online event on occupational safety and health of nurses in India on World Patient Safety Day on 17 September 2020 that was organized by this study group, has been incorporated in

this study (details and report of event in Annexure 3).

Challenges and problems faced in getting nurse respondents due to the COVID-19 pandemic

Primary data collection through personal in-depth interviews was to begin in April and completed by June.

While we were aware of the challenges involved in getting nurses to consent for a meeting, we were not at all prepared for the effects of the COVID-19 pandemic that started spreading soon after we started the study in early March. Together, the massive impact of the pandemic itself on hospitals and health care workers, and the extraordinary situation and uncertainty created by the total lockdown in Delhi, derailed the process of contacting respondents and scheduling appointments for an interview. We had reservations regarding conducting online interviews, especially with hospital management not being accessible or not agreeable to such interviews. We needed to travel to the hospitals and meet them to get an appointment for even online interviews. Besides, we had apprehensions about the quality of interviews because not all respondents had access to technology and a stable network or tools such as laptops and computers for online discussions. Hence, we waited for the lockdown to ease so that we could meet prospective respondents, explain to them the objectives and method of the study, and schedule face to face interviews or online interaction based on their convenience.

While we completed our planned number of office bearers and other key informants, the progress with nurses' interviews was affected adversely due to the severe impact of the pandemic on the hospitals and the nurses. While contacting nurses during the lockdown, we came to know that many have either: been told to not come for duty or contracts have not been renewed, or have resigned on their own and left the city. Together, these developments in May-July period eroded the pool of nurses from which we had hoped to get respondents for our study. Study group members were regularly contacting and following up with a dozen office-bearers and contacts (in all 52 persons) to obtain access to nurses. In this situation of uncertainty and insecurity, nurses we contacted and followed up, either declined to participate or stopped responding, despite our assurances of complete anonymity. Secondly, given the load on hospitals during that time, as well as the media attention on them (often negative) for their treatment of nurses, we were also unable to contact hospital managers/owners for the interview.

Given this extraordinarily difficult situation confronting us, it has not been possible to complete the planned interviews. By end of September, we completed 21 interviews with nurse respondents and key informants and one FGD with 12 nurses, of which seven were female and five male. In all, 31 nurses were interviewed, 19 in person and 12 in an FGD. Of these 31 nurses 15 were female.

Of the 31 nurses six were also office-bearers of nursing associations, as shown in Table 2.1. Two of the respondents were lawyers, of whom one has represented individual nurses and/or associations in the courts. The other KI was an advocate specializing in labour law.

The profile of the respondents is as shown in the table below.

Table 2.1: Profile of respondents

S.No.	Respondent profile	M/F	Code no. in report
	Nurse respondents		
1	CCU Nurse in 200+ bed hospital of a corporate chain, with more than 10 years of experience, currently working as the Team Leader; earlier experience in small hospitals, and a stint in an African country through a government programme	M	N 1
2	Staff nurse with four years of experience in two non-corporate hospitals, at time of interview out of work from the 150+ bed hospital because of downsizing during COVID-19 pandemic	F	N 2
3	Staff nurse working for past two years in a 200+ bed hospital of a corporate chain; has experience of working as a nursing tutor for two years	F	N 3
4	Day-care nurse at 500-bed hospital of a corporate chain for the past four years	M	N 4
5	Nurse with around three years' experience in two different hospitals, post-graduate in Nursing, resigned recently from position in corporate hospital	F	N 5
6	In-charge at a non-corporate, 100+ bed single-specialty non-corporate hospital with 10+ years' experience, post-graduate in nursing	F	N 6
7	In-charge at a 200+ bed non-corporate hospital for the past 20 years, earlier experience in smaller hospitals	F	N 7
8	Team Leader in 100+ bed hospital of a corporate chain, with more than 10 years' experience; about 3-4 years in 50-bed hospital	M	N 8
9	Infection control nurse in 500-bed hospital of a corporate chain for the past seven years; diploma in hospital infection control from earlier hospital he was working in; stint in a middle-eastern country through government programme	M	N 9
10	In-charge in emergency at 400-bed, non-corporate hospital (trust hospital) for the past 12 years, previous experience in nursing home	M	N 10
11	Team Leader in 75-bed hospital of a corporate chain for the past five years, previous experience in three small-medium hospitals, of which one shut down	M	N 11
12	Staff nurse since two years in 450-bed trust hospital attached to medical college	F	N 12
13	Nurse in ICU in 500+ bed hospital of a corporate chain since 10 years	M	N 13
	Key informants		
14	Office bearer, with work experience as nurse and professor	M	OB 1
15	Office bearer, currently working as nursing supervisor in 200+ bed corporate hospital; 16 years of work experience	M	OB 2
16	Office bearer – was working as staff nurse; removed after being part of a strike in hospital, ongoing case in labour court	M	OB 3
17	Office bearer – working in a government hospital	M	OB 4
18	Advocate, taken-up several cases of violation of nurses' rights in Delhi courts	M	KI 1
19	Nurse-cum-midwife, with post-graduate qualification, in policy advocacy	F	KI 2
20	Specialist nurse with 13 years' experience in 100+ bed single specialty non-corporate hospital, completed specialized course in hospital; one year in corporate hospital as nursing quality manager, not working at the time of interview	F	KI 3
21	Advocate specializing in labour law	F	KI 4
	FGD with seven female and five male nurses, all with up to five years' experience in different departments in same hospital		

A review of accreditation standards and nursing excellence standards of NABH was done by a student intern from Azim Premji University, Bengaluru, as part of the desk research for the study.

Limitations of the study: Due to the challenges discussed above, the study has the following limitations:

We could not speak to nurses from less than 100-bed and smaller hospitals or single-doctor owned and charitable institutions. However, several of our respondents had worked in such hospitals and shared their experiences of the scenario in some such hospitals.

We could not speak to hospital management and government representatives. However, their views have been covered to an extent from the desk research of relevant documents, and at the online event that the study group had organized during the course of the study on occupational safety and health of nurses.

While the nursing workforce is pre-dominantly female, we could not talk to as many female respondents. Among the 52 persons who were contacted by the study group members at least 12 female respondents, junior and senior nurses, declined to participate.

Data analysis

Interview recordings were transcribed, translated where required, and stored along with the written response and other notes in NVivo software provided by WHO-India Office. They were subsequently coded and analyzed thematically by Indira Chakravarthi and Ipsha Chaand.

An initial set of codes was developed based on the broad themes that had been discussed in the study group, literature review and the interviews.

They then read each transcript line-by-line and coded their contents under these initial codes, as well as modified or added new codes as required.

Codes were then grouped into the earlier themes and the relevant findings are presented and discussed in the following sections. The study attempts to adopt an interdisciplinary approach; it uses the health systems and political economy framework, concept of decent work, and sociological concepts regarding gender and professions.

Section 3

Findings and discussion 1:

3.1: Employment: recruitment and terms of employment

3.1.1 Recruitment

The recruitment process is crucial in shaping terms of employment offered by hospitals to nursing professionals. There are three main processes by which the medium and big private hospitals recruit nursing staff: campus placement, walk-in interviews and through agencies. They seem to adopt more than one of these processes for recruitment of nursing staff, depending on the numbers and cadre of vacancy. The recruitment process in turn determines the ability of a nurse to negotiate their remuneration and terms of employment.

Campus recruitments - Private hospitals in Delhi recruit bulk of their nursing workforce through campus recruitments. Nursing colleges inform hospitals about the batches nearing completion of their studies. Hospitals that have their own training institutions reserve vacancies for the final year students. In this process of recruitment, the applicants are not informed about the responsibilities or remuneration. Nor can they negotiate on the remuneration offered by the hospitals, as described by one respondent (N3): “They (hospital management) came and conducted interviews and selected around 10-20 students. We were then asked to go to the hospital personally to complete next steps and medical tests. They don't clearly give all the information about salary and whether we will be contractual or regular.” They are also often employed at a lower salary, of around US\$ 203-243 (₹15000-18000) as compared to those recruited through open interviews who start at between US\$ 270-338 (₹20000-25000).

Walk-in interviews - The process of open interview or walk-in interview is adopted when there are few vacancies or when nursing professionals with a certain training and work experience are required for a specific post in a certain department. There are two different ways in which walk-in interviews are conducted: open interviews and direct approach.

The hospital human resources (HR) department shares information regarding a vacancy with the staff of that unit so that it can be circulated among their professional circles. The staff members then pass on information to other nurses, whereupon nurses who are seeking a job approach the hospital HR for interview. In such a system, the applicant has minimal knowledge regarding the job description, position, salary, or the terms of employment.

In direct approach method, the hospital places a formal advertisement regarding the vacancies on various online platforms. Even in this recruitment process, the hospitals specify the post but not the work responsibility or remuneration. It is only after appearing for the interview and getting selected that the applicant gets to know about the work, responsibilities, and remuneration.

However, the applicants may negotiate remuneration after they clear these stages. Some hospitals accept applications throughout the year and call the applicants for an interview whenever there is a vacancy.

Recruitment through agencies - Some recruitment within private hospitals also takes place through recruiting agencies. As told by a Key Informant (KI 2), “There are middlemen who help you to get a job.

They are critical in making the negotiations on your salaries and what you get". There are middlemen who facilitate the process of employment search and job interview for nurses. They also provide assistance to private hospitals in the process of recruitment. In such an arrangement, the HR department reaches out to these agencies for applicants. These agencies bring suitable applicants to the hospital for recruitment and the HR department conducts interviews.

When the recruitment process is over, these agencies take some commission from the hospitals as well as the candidates who get selected. Under such mechanism a nurse does not have the power to negotiate the terms of employment, remuneration or the employment benefits provided by the hospital. The salary level is set by an agreement between the hospital and the recruitment agencies. Once the recruitment process is over the agency does not take any responsibility for remuneration and other entitlements and working conditions, as told by a senior office bearer of a nursing association. According to an office-bearer (OB 1), such outsourcing of recruitment of nurses to agencies or contractors was not as prevalent in the private sector as it is in government hospitals. It is a 'growing practice' and is adopted more by those in Delhi and by the new All India Institutes of Medical Sciences in different states.

Experience in a small hospital - While these are the recruitment mechanisms of the big, corporate hospitals¹¹, one male nurse (N 11) described his experience at a small, single-doctor owned hospital when he came to Delhi in 2007, after his studies along with several other batchmates. "It was very hard for male nurses to get a job. After a tough time, we got to know that two friends wanted to leave the small hospital they were working in, but the hospital was not allowing them to leave, on the ground that it would not get any nurses if they left. Hence the only option was that they arrange for two nurses to replace them. So that was our chance, and we joined that hospital and our friends left. So that was the condition in Delhi at that time, the hospitals were making rules for themselves, they did not bother about what the government says and whatever the public says.

The important thing was that the salary was on daily basis, of ₹100 (just over one US\$) a day. So, if you worked for 25 days in a month you will get a salary of ₹2500 (US\$ 34) and if you could work for 30 days, you could always get ₹3000 (US\$ 40).

So, there was competition among the employees to work for 30 full days in a month without even having rest for a day. So that was pathetic ..., it was not a sophisticated hospital which will have a protocol and policies for the employees. That was my experience in small hospitals, all the other hospitals I worked in were established ones, corporate hospitals. The rules and regulations were always there, a contract was signed, so there were no issues regarding the work hours or salary. They are supposed to abide by them".

3.1.2: Terms of employment

At the time of recruitment, the nurses are required to sign multiple documents. Most of the respondents reported that they do not get sufficient time to go through the documents before signing. According to one nurse respondent (N5), "They make us sign a lot of papers in which a lot of things are written and they don't give us enough time to read all the documents they are giving us and maybe the documents could be saying that collective bargaining or union activities are not allowed. So, we get legally bound by many such documents".

Submission of certificates/post-dated cheques

As mentioned earlier in 1.2.6, till 2011 many hospitals practiced a form of 'bonded labour'.

They would retain the certificates of fresh recruits as a guarantee that they would not leave for a certain period after joining, say two or three years. If they wished to leave they would have to pay a fixed amount of ₹2-3 lakh (US\$ 2 707-4060) to get back their certificates. While this practice has been banned, however, a

¹¹ When asked about what are 'corporate' and 'non-corporate' hospitals, the respondents explained that the hospital chains, such as Apollo, Max and Fortis, are corporate, and often single-doctor owned big or small hospitals that are stand-alone single hospitals are non-corporate, such as Moolchand, Saroj, Agrasen Hospital.

lawyer informant (KI 1) mentioned, “now-a-days the hospital is not taking the certificates, instead they are taking post-dated cheques (PDCs) for ₹50 000 or 60 000 (US\$ 676 or 812). We find 2-3 cases against X hospital and Y hospital.... you may come to know that still such practices are followed by some hospitals. Legally we could settle this bond system, it is no longer a mandate or legal practice. It's an illegal practice”.

Probation/induction training

Some of the respondents reported that the hospitals recruit fresh graduates who then work as trainees for a stipulated period, commonly known as probation period, which could vary from 15 days to a few months.

During this period, these freshers are not appointed to any specific ward/unit but made to work as trainees and may be given extremely low salary, or no salary or other employment benefits. All new recruits, fresh or those with previous work experience must undergo some form of training that may extend for one week to one month, depending on the hospital policy¹², after which they must clear an internal exam to get confirmed as employees in the hospital. Those nurses who clear the exam get a written document/offer letter confirming their employment within the hospital, which means they are now an employee of the hospital. This is when the salaries of nurses are increased and they become eligible for other employment benefits.

Those who do not qualify internal exams are either dismissed or continue on probation till they clear the assessment, or kept on the job but provided very little or no salary till they clear the assessment. The corporate hospitals seem to provide a more formal contract letter to their employees mentioning the specification or job profile, salary structure, code of conduct, hospital policy and employment benefits as compared to the non-corporate hospitals which do not hand over very detailed employment contracts¹³.

Fixed term contracts as regular employment

Once the recruits complete their probation/training period and are made employees, they are employed under fixed term contract: namely employed for a fixed period (less than a year or 2-3 years) and the contract is then renewed at the end of the period. As N 1 explained, “After completing my interview, I will get an offer letter saying that the first 6 months will be probation period, if my performance is good, I will be made permanent. But that “permanent” is not like permanent employment in other organizations. If they are keeping us as permanent employee, we should get all benefits as a permanent employee. But this is only contract for another one year. After completing six months of probation period, then they will just extend it for another one year. It is not permanent employment it is just contractual period of one year. That is the difference. Then every year they will keep repeating the same, renewing contract one year at a time. This is not what permanent employment means, this is for only one year”.

The terms for renewal of employment contract seem to vary across private hospitals.

In some hospitals to secure renewal of the employment contract, each year nurses need to undergo assessment process (written test and interview) by the HR department. If nurses fail in the assessment, their employment is discontinued, whereas if a nurse qualifies the exam their contract is renewed for another year.

In some hospitals the management policy is to renew the employment contract based on annual appraisal made by the supervisors, nurse superintendents (NS) and head of the department (HOD).

Most of the respondents mentioned that the HR department plays a significant role in this procedure, to the extent that the HR makes the final decision often undermining the appraisal given by NS/HODs. One nurse mentioned that in her hospital, of the 40 nurses, whose contracts were due for renewal, only 10 were renewed. Another nurse shared that her contract was not renewed, even though “the HOD had written that

¹²It seems that corporate hospitals have a structured training program where the new recruits are assigned a mentor or undergo compulsory induction program where they attend regular classes for a certain period of time as compared to non-corporate hospitals where training/induction is limited to supervise hands-on-training.

An employee may seek a copy of the contract document from the HR department, otherwise formal documents are not provided on recruitment.

she is hard-working and highly recommended for extension, with increment” (N 12). This is used as a mechanism of control over the nurses, as in this case the said nurse had been part of a group of nurses that was demanding PPEs and other facilities and monetary allowances during the COVID-19 pandemic. She was told by the management “who is this person - he is not authorized at all (to conduct this evaluation)”. We were also told that the contract of another nurse was not renewed on grounds that her husband was involved in organizing the nurses in the hospital, although he was not employed there.

Such fixed term contracts do not guarantee any job security to the nurses or the entitlements that they would receive as permanent employees, such as gratuity or pension. As reported by our respondents, the nurses are employed on contracts, which are renewed for up to 10-15 years. This system makes it easy for the hospitals to employ and dismiss nurses from duty with little accountability towards their labour rights and to make them work on lower salaries. Since the decision to renew or discontinue the contract rests with the management, the nurses are under constant pressure to perform and submit to the decisions of the management, with often very little power to bargain even for basics such as nurse-patient ratio, leave, increment, facilities at workplace, etc. According to N12, the senior staff in the hospital where she worked were permanent staff, probably referring to the supervisors and superintendents.

The association of private hospitals with training colleges make it easier for them to hire inexperienced nurses at a low pay scale for 2-3 years without employment benefits, promotions, or annual increments. After 2-3 years, the administration discharges the nurses from duty and replaces them with fresh graduates.

This system enables the hospital management to maintain a low pay scale and avoid the expenditure on additional employment benefits they would otherwise have to provide on recruitment of a permanent employee or an experienced nurse. As one senior nurse who is also an office bearer (OB 4) explained, “The private hospitals do not want to employ on long- term basis, but just one or two years. They do not want to renew the contract, to give any increment. They are trying to give a good package to new recruits. They do not want to entertain the senior people - by senior people I mean the experienced ones.

They try to create ego issues also. Like if my junior is being paid better salary than me, then I don't want to work there. So I will leave. At the same time, if someone is saying you are not giving good salary, they will say that we are giving juniors, or new recruits this much salary.

These are the tactics (adopted by private hospitals)”. The implication of this type of contractual employment, as rightly pointed out by the lawyer (KI 1) is that there “is no job security; it is very easy to hire and fire. Once the contract period is over, again the same process is followed (of interview etc.), or it is up to the management to decide. If there is continuity of service, the employee, will be at peace. They know that they can work in a comfortable atmosphere, but if it is only for a fixed term, then he can be terminated any time. Most important of all, there are so many benefits a permanent employee is entitled to under the labour laws. Once an employee is working continuously for five years, he is entitled to gratuity, so there are so many things that the hospitals must give the employee. To avoid all these, now not only hospitals, all the employers are actually going for this contractual labor.”

Remuneration

Almost all the respondents referred to the large disparity in salary between the public and private hospitals. As they pointed out, the remuneration offered to nurses in the private sector hospitals is low in comparison to public sector nurses across cadre, irrespective of their work experience, skill or training. According to OB 1, “the most important thing is the salary, which is basically in the private sector, not in government. In the government sector salaries have gone for a good change in last 20 years - consistently increasing and it is reasonable. Maybe trade unions might say it is not, but to be honest, it is reasonable. In private sector it is really low”. The following responses illustrate how low the salary in the private sector is, in absolute as well as relative terms. “The difference is so big - the government hospitals give ₹70 000-80 000 (US\$ 947-1 083) as starting salary, whereas private hospitals give up to ₹20 000 (US\$ 270), and not always even that amount. They will say ₹20 000 (US\$ 270), but then they will give ₹10 000 (US\$ 135) as starting salary”,

said another office bearer (OB 4). According to a nurse (N3), “There is a huge difference. I can say that the nurses who are working in the public sector are getting three times better salary (than us)”.

Another nurse (N4) made similar observations. “If we compare salaries in the two sectors, salaries in the private sector are only 30% of the salary in government hospitals. The starting salary of a fresher in a government hospital is more than ₹50 000 (US\$ 677). Yes, starting is 50+. My classmate joined a state government hospital after a year's experience, her salary is ₹60 000 plus (US\$ 812 plus). And mine is only 30% (of hers)”.

According to N5, “At least in the hospitals with 200 or more beds nurses should be given equal salary as in the government sector, but nurses are still getting between ₹17 000-21 000 (US\$ 230-284) in private sector, while in the public hospitals, they are earning between ₹80 000 to 100 000 (US\$ 1 082 to 1 353).

Though the situation is better in Delhi, in other states it is far worse. There, nurses are earning less than ₹10 000 (US\$ 135) even after studying a 4-year BSc nursing professional course. They are paid 1/5th the salary of a nurse in government hospitals. In the end, after dedicated service if we are not paid properly, the pay will determine our status and the profile of our profession. If that is not met, the profile will always be low in the eyes of the society”, N5 said.

The difference in salary between public and private hospitals was explained by N 8: “One will not find conditions like public hospitals in any private hospital. There is a difference in salary, then there are allowances and the cadre is secure. Whereas even though we are secured, management can take any action against us, but this is not possible in the public sector”. According to N10, “The minimum a fresher nurse will get is ₹17 500 (US\$ 237).

If they work in high-risk area, they will get ₹1 500 (US\$ 23) extra”. When asked about the type of hospitals that paid such low salaries, it was told that all hospitals - small, medium, big, paid such type of salaries: “Big ones also. I know many of the big ones nearby. My colleagues, who have left my hospital and joined big hospitals are also not getting proper salaries. They are told if 'you need a job, you have to work this way will get this salary only'. The HR people will decide” (N9).

During the FGD one of the nurses said, “Salary of the staff here is not more than ₹22 000 (US\$ 298). I am on duty in the ICU, still my salary is the same. The salary of those in the wards is also the same – whether in COVID ward or non-COVID. An increment of 5% is given if we get an extension after one year, not if we get it are (hired) for six months. There is no ICU allowance, no casualty or LR (labour room) allowances.

Box 3.2: Aspiration is to be paid at least ₹40 000-50 000

“At the very least, nurses should get ₹40 000-45 000 (US\$ 541-609). I am not asking for so much, like the government hospitals, where nurses are receiving ₹60 000 -80 000 (US\$ 812-1 082). But nurses should be paid at least ₹40 000 (US\$ 541) because they are studying so much and there is no value for that. In ₹20 000 (US\$ 270) in this situation - especially in Delhi- how will they survive? Nurses come here from all over India - from Manipur or Kerala or Rajasthan. They don't have their own houses, so they live in rented accommodation. They won't even be able to pay their rent - you know the rents in Delhi. If you want one room, you have to pay around ₹8000 -9000 (US\$ 108-120) rent monthly. I am living right now on rent, I pay ₹8500 (US\$ 115), plus electricity, water and our daily expenditure” (OB 3).

In ICU I am handling four patients, which includes patients on ventilator. And in the ward the ongoing ratio is 1:20, 1:22. We all get the same salary”.

Even within private sector, the salary of nurses varies between corporate and non-corporate hospitals, and even within the same hospital. “Delhi hospitals pay much better than those in Bangalore or Kerala”, according to N1. According to N13, “When I was getting ₹30 000 (US\$ 406) here, another big corporate hospital offered me ₹50 000” (US\$ 676).

While in corporate hospitals the starting salary for a junior nurse is not below US\$ 270 (₹20 000), in non-corporate hospitals the starting salary varies between US\$ 149-243 (₹11 000-18 000). According to a nurse respondent with about 4 years' experience in a non-corporate hospital (N2), "I was told that 'since you are a fresher, you will get only ₹9000 (US\$ 122) as salary'. Our basic pay was ₹11 000 (US\$ 149), even today our basic pay has remained the same. And I have completed six years at the hospital. We get ₹15 000-16 000 (US\$ 203-216) after working overtime. Sometimes we get ₹17 000 (US\$ 230), otherwise ₹15 000-16 000 (US\$ 203-216) is the maximum salary for everyone". On the other hand, a nurse with 10-12 years of experience can earn a monthly salary of around ₹28 000-35 000 (US\$ 379-473). This is the gross monthly salary and final amount after all the deductions¹⁴ is lower. In the corporate segment of the private sector the maximum that nurses get for 8-10 years of work is not more than (US\$ 676) ₹50 000. According to N13, "Starting salary was ₹20 000 (US\$270). Now, after 10 years it is around ₹40 000 (US\$ 541). There is not much difference in salary of bedside nurses and team leaders.

The maximum can go up to ₹65 000 (US\$ 879) for in-charge".

The salary of a fresh graduate or a nurse with a work experience of 2-3 years is fixed by the management and is non-negotiable. Those graduating from the nursing college of the hospital and getting employed in the hospital were paid lesser amounts than other freshers, as told by some respondents. As explained earlier, fresh graduates are recruited as trainees and are paid remuneration below US\$ 135 (₹10 000) or none at all. It was found that across private hospitals, the salary of nurses is below minimum of US\$ 270 (₹20 000) prescribed by the Delhi Government order (Discussed in Section 4). Nurses therefore feel, "We come after completing three and a half years of nursing training and paying ₹3-5 lakh (US\$ 4 060-6 767) for the nursing course, still the corporate hospitals hire us as trainee. In so many private hospitals they have very poor salary for the fresher. If I am coming after completing a training that has cost me ₹5-7 lakh (US\$ 6 767-9 473), then why is my salary is so less?" (KI 3).

According to a nurse-office bearer (OB 4), "After the courses are over, the plan that freshers have in mind is that they will work for two-three years to gain experience and then go abroad. Or they will crack some government exam and get employment in some government hospital. They view this as a temporary phase and that is why they are willing to work for less than ₹5-10 000 (US\$ 67-135). This the private hospitals are exploiting. Before 2011, freshers were made to work as trainees on a stipend of less than ₹5000 (US\$ 67) for one or two years. But this system was banned in 2011 by the government. After that the private hospitals are taking these freshly graduating students as junior nurses and paying them ₹5000 (US\$ 67) or even less. But it is difficult to get a job, so everyone is agreeing to this type of arrangement". Another office-bearer (OB 1), who is also a professor of nursing, associated this practice of low to no remuneration to fresh recruits with the poor quality of education in the private nursing colleges that have sprouted in large numbers since the year 2 000. These colleges lacked hospital facilities for training the nurses, so when the students passed out, they wanted to have some hands-on experience. According to him (OB 1), "In Karnataka itself there were more than a thousand nursing colleges, but less than 200 hospitals. These students were even ready to pay for their experience to work in a good hospital, because there is no nursing without hands on experience. Even after paying money it was difficult to get training, because you cannot afford to have so many trainees at a time". So far from expecting a good salary, fresh nurse graduates were willing to pay to get training, or work without salary for some time. The latter experience was also narrated by a male nurse (N1).

It is only for the past 2-3 years (post 2018) that some of the corporate hospitals are paying fresh graduates a starting monthly salary of US\$ 270 (₹20 000)¹⁵, following the recommendations of the JP Committee appointed on the orders of the Supreme Court (discussed in Section 4).

Nurses with good work experience, working as team leaders or nurse in-charge earn a monthly salary of

¹⁴The deductions are made under various head such as Provident Fund, Hostel accommodation/food, penalty for late arrival, error on duty etc.

¹⁵The salary of US\$ 270 (₹20 000) is the gross salary. The amount of US\$ 270 stated to nurses during recruitment is CTC and the final amount that nurses receive after all the deductions come to around US\$ 230-243 (₹17 000-18 000).

around US\$ 473-609 (₹35 000-45 000), whereas the nursing superintendents get a monthly salary of around US\$ 1218-1353 (₹90 000- 100 000). There is no fixed salary structure for nurses employed in a specific cadre and each nurse needs to negotiate the salary at recruitment time, as described earlier. Respondents said the salary of nurses with same experience and cadre (for the same department) might vary based on the agreement between the employee and management during recruitment. Those with same work experience can be offered different salaries when they are freshly employed for the same post in the same department on the same date. As stated before, the prior work experience is an important marker for determining the capability of a nursing professional to negotiate salary. A nurse with some work experience is in a better position to bargain for salary and often manage to negotiate a salary scale higher than what offered by the management.

According to one respondent (N 8), “Hospital will mention some amount (cost to company CTC) and the candidate may not agree to that CTC. If he is coming from another hospital, he will say this is too small and so there is negotiation. If there is a shortage of staff and the hospital urgently needs to fill the vacancies, the HR may agree to a salary close to the amount asked by the new recruit”. Such negotiation is easier for senior nurse staff or those with some specialized training, say ICU nurses, and not so much for fresh nurses. However, the hospital does not always give the salary asked for by experienced nurses. One nurse (N1) pointed out, “The main problem is that the experienced staff should not lose their job. If I lose my job it is very difficult to find another one because the private hospitals prefer fresh staff as they have to pay only ₹18 000 (US\$ 243). If I am coming from a hospital (with experience), I will ask for salary around ₹60 000 (US\$ 812) and will ask for a team leader or in-charge post. They (hospital) will say, "you can just go, I will take 3 or 4 fresher staff" instead of taking me”.

One respondent, an infection control nurse at a corporate hospital (N9), drew attention to the issue of charges taken from patients but the benefits not accruing to nurses' salaries: “There will be different kinds of hospital charges, like nursing charges, injection charges, IV charges, IV canula charges, dressing charges, these all relate to nursing practice and come under nursing charges only. The staff will be made to do the work, but no salary is given as per their work. They are charging from the patients, but they are not providing that kind of salary to the nurses. Yes, obviously some kind of consumption will be there, that has to be charged, but the procedure charge is different, that the nurses are doing. During the billing, the patient gives the feedback that there are so many charges and the patient is not satisfied. They add many charges, but it is not coming to the salary of that particular staff”. Another issue was that of salary not corresponding to the workload: while the shift is for six hours, tasks such as handing over the patient files to the next staff etc. extend the work hours to almost 7-8 hours, which is not compensated by overtime. They may also be assigned other non-clinical tasks (N1).

Regarding deductions from salary, N9 pointed out, “I have to add this point also. If something is missing or lost from the hospital department - BP apparatus, or stethoscope - the blame is placed on the nurses, and they have to pay the money. That amount is deducted from their salary. The management will not take any action, they will not go for any investigation regarding who has made the mistake; they will not go into that, it is only the nurse's mistake, and deduct from the salary for the following month. The management will decide”.

These and other responses point to the arbitrariness exercised by the management in fixing the remunerations for nurses in private hospitals as also their flouting of government regulations (Discussed in Section 4), as captured in these statements by different nurses: “It is totally up to the management. The management is the one that decides who gets this much amount” (N1). Says a nurse working in a government hospital, an office bearer (OB 4): “Actually, in private sector, there are no clear (rules) regarding the salary at the time of joining, what is the increment, what is the promotion, as it is in the government sector.

The salary, the increment, everything depends upon the management”. Says nurse N5: “The issue is not

how much we are made to work, it's ok. The issue is that we are not paid according to the government regulations, according to the recommendations of the committees. Our rights have to be met”.

Increments and promotion

“My starting salary (as staff nurse in the year 2000) was ₹5000 (US\$ 67) and now I get a salary of ₹35 000 (US\$ 473). In 20 years, this is how much my salary has increased”, said one respondent working as critical care in-charge in a 240-bed non-corporate hospital (N7). An office bearer (NS 05) had this to say about the situation in another 600 bed teaching hospital, “Those who have been working for about 10 years now must be getting ₹26 000-28 000 per month (US\$ 352-379). Mostly they give an annual increment of ₹500-900 (US\$ 7-12).

What happens is: with those who have experience, and are getting about ₹26 000-28 000 (US\$ 352-379), the management will do a review, hold an interview and then tell them their performance was not good and then dismiss them. The hospitals just do not want to give more to the staff. There are some hospitals, like X and Y (corporate chains), that give up to ₹35 000 (US\$ 473)”. This was corroborated by nurse respondents from respective hospitals.

Nurses from the non-corporate hospital reported that they received very little increment and a couple of others from two different corporate hospitals were receiving salaries of US\$ 473 to 541 (₹35 000 to 40 000) respectively after more than 10 years of working as critical care nurses.

All respondents reported that their hospital had a policy of providing annual increment. In some it was tied to the performance appraisal of an employee by concerned NS and HOD and in some hospitals, patient feedback was also taken into consideration¹⁶.

According to one respondent (N11) “corporate hospitals rated the employees into categories such as 'met expectations', 'did not meet expectations', 'exceeded expectations', and 'far exceeded expectations'. So the employees who come into the 'far exceed expectation' will always get a good increment and the employees who are falling into the category of 'did not meet expectations' do not get the expected increment. Some hospitals give some reward for individual performances, but that is not a mandatory rule by the government, it is implemented by the corporate hospital just to motivate the staff”.

Hospitals do not follow a fixed standard of increment for all employees. As with remuneration, increments too depended on the decision of the HR department. In due process, nurses working in certain areas such as OPD and certain wards go unnoticed.

As reported by one respondent (N11), such nurses do not have a designated supervisor to observe their performance or recommend for increments/promotion. These nurses eventually fall into the category of unidentified talent who do not get annual increment. Some respondents reported that the HR may or may not consider the appraisal and feedback from the concerned in-charge or NS and withhold increments year after year. The promotions are not entirely based on work experience of a nurse but also depend on the interpersonal relationship of a nurse with superiors and the management.

The career growth is not uniform for nursing professionals and candidates who support the management are handpicked. While post-promotion there is a change in designation and job responsibilities of a nurse, there is hardly a substantial change in their salary. The management prefers to give early promotion to fresh graduates while keeping their salary at a minimum of US\$ 298-338 (₹22 000- 25 000) in comparison to recruiting a more experienced nurse at a higher salary of about US\$ 473 (₹35 000). “Designation changes (after promotion) but salary hardly increases by five. If they give an increment my appraisal has hardly

¹⁶The appraisal of each nurse staff was submitted to the HR department along with a feedback on increments. The performance was rated based on different categories such as: 'met expectations' and 'did not meet expectations' and 'exceeded expectation' then 'far exceed expectations'; or Grades-I, II, III. Accordingly, an employee is eligible for a certain percentage of increment. The corporate hospitals provide a maximum increment between 15%-25% whereas non-corporate hospitals provide maximum increment of up to 10%. However, these annual increments were not mandatory; for corporate hospitals it depends on the profit made in a financial year, whereas for non-corporate hospitals the decision to provide or not provide or how much to provide was made by the HR department.

reached ₹150-250 (US\$ 2-3). I haven't got more than this yet" (N4).

Some respondents reported that the nurses are promoted but the same is not recorded in any written document. The nurses are orally informed of their promotion and subsequent change in designation and responsibilities. However, they do not receive any documents that spell their responsibilities. A major disadvantage of this practice is that actual work experience of a nurse is not reflected in their work certificate when they leave that organization.

"Those who can control unit very well they will give the post as a TL, but not in a paper, and there is no change in salary, only the responsibility will change" (N1).

After a few years, prospects of increments and promotions become stagnant and the nurses have no choice but to try to switch to a better-paying job in another hospital. As reported by the respondents, salary is a major concern among nurses, as in this profession income is a crucial marker of their career growth. Therefore, switching institutions serve as a better option for fresh graduates or junior nurses (with less work experience) to secure a higher salary.

3.2: Working conditions

3.2.1: Nurse-patient ratio

The nurse respondents working across private hospitals reported heavy workload and low nurse-patient ratio in their respective departments. They are expected to manage 18-20 patients in general ward and 3-4 patients in critical care unit¹⁷. "We have even handled ratio of 1:30 ratio and 1:22 is normal here. When it is very busy in the wards and some patients are very sick, we ask for staff to assist us.

On rare occasions we get some help, but often we are told, "can't you handle 18-20 patients? In our times we would handle so many patients at a time" or "there is no staff, from where will we provide you with help?".

In such situations, there is no concession that we should be allowed to do the important tasks, it doesn't matter if one or two minor things do not get done; they just want everything thing to be completed." (FGD).

The nurses are expected to manage clinical care with a low nurse-patient ratio and also to complete the non-clinical work on time. The respondents shared that high patient load and additional work burden act as hindrance in carrying out their actual responsibility and hampers delivery of quality care to patients. In rare occasions, such as during dengue season when there is sudden increase in footfalls, the management pulls staff from other departments and posts them in those which require additional staff. Under such immense work burden if there is some error on the part of nurse staff, they become answerable to the NS and need to submit written explanation to the management.

"Patient care is not just instruments, is it? One requires people who can run these instruments too, is it not? So that ratio needs to be there too, right? For example, there is one nurse working in the ICU, she is looking after 3-4 patients, if at the same time two patients collapse, where will the nurse go?" (OB 3).

According to OB1 corporate hospitals had a better nurse-patient ratio than non-corporate hospitals, as they were able to employ more staff as compared to smaller or non-corporate hospitals, which preferred to function with minimal staff in order to keep their running costs low. All the respondents perceived that the heavy workload they faced was due to inadequate staffing, and if adequate staff was recruited their work burden could reduce.

"When I joined here, there was 1500 nursing staff in the hospital. Then numbers went down, at present our nursing staff is 800-900 for the entire hospital. This is why we have a higher workload. If we have a good

¹⁷The recommendations of nursing staffing norms by the Staff Inspection Unit (SIU) that has been endorsed by the Indian Nursing Council, is that the ratios should be 1:6 in normal wards, 1:4 in special wards, 1:2 in nursery and 1:1 in ICU, 1 for every labour table in labour room. See also Section 1.2.3 and <https://www.indiannursingcouncil.org/pdf/ICNGoldenJublie.pdf>

number of staff then our workload will also reduce. There is huge difference in the staff that they used to hire previously and now. If earlier they had 50% staff, then now it is only 20% of the required staff.” (N4).

Apart from nurse-patient ratio, the condition of the patients also determined the work load of nurses. In the accredited hospitals, nurse-patient ratio is maintained based on the condition of a patient. The respondents perceived that fixing a nurse patient-ratio is effective if the patient allocation is done judicially. If one nurse is allocated 2-3 critical patients and another 4-5 stable patients, then the workload of the former will be higher. Many of our respondents also mentioned that nurses are allocated patients by the senior staff based on their interpersonal relationship and favouritism is rampant; those nurses who please their seniors are given less work.

“Even a fixed number of patients per nurse may not be appropriate because in the five patients a particular staff gets, someone may be more critical and some maybe manageable. So when one nurse gets five critical patients and another gets five normal patients, I think it's still not right. Nurse-patient ratio should always be decided by the team leader or supervisor of the department after seeing the condition of the patients ... so our whole aim should be patient recovery. If you give one or two critical patients for one nurse, then no one is going to benefit” (N11).

3.2.2: Work load, working hours, basic facilities at workplace

Apart from clinical care, nurses are burdened with many non-clinical responsibilities. Often they are the ones held accountable for smooth functioning of their department and completion of all documentation.

In the hospital every employee and every department have their assigned responsibilities, but because of the hierarchies entrenched in health care institutions, it is common practice to pass on the work to nurses and hold them accountable for everything. The doctors, superiors, subordinates and even support staff take advantage of this work culture to pass on their work. If doctors do not want to do some work, they transfer it to the nurse. It was reported by the respondents that nurses are usually buried under additional work, such as paperwork and documentation. Nurses are expected 'to multi-task' and compelled to handle work other than their clinical responsibilities. Even the responsibility of cleanliness and sanitation of the unit are passed on to the nurse and not the housekeeping staff. In case of any mismanagement, nurses are held responsible and are answerable. According to N1, “Nurses are held responsible for teacups lying around left by others, or if there is a single mosquito in the ICU, even though there is house-keeping staff. We are nurses not MBA (Master in Business Administration). We are technical people who come here after studying for three years, we study anatomy, about human body. Managing patients clinically is easy as we are trained for it, but other jobs are stressful, are a problem; additional non-clinical responsibilities are the problem - if there are delays in billing, it is the responsibility of the finance department. We are not treated as professionals; we are technical people and should be treated accordingly”.

According to most respondents, the work responsibility and burden is highest for the bedside nurses working in the ward. They are assigned 5-6 or sometimes even more than 20 patients during one shift. They are responsible for patient care as well as maintaining all documents.

The burden of work is so high that at times they do not even get time to eat or drink water during their shift. The respondents shared that maintaining of nurse-patient ratio is crucial for their work as well as delivery of quality patient care. The respondents say that if nurse-patient ratio is low and additional work burden is put on them, they are unable to concentrate in their work and therefore bound to make medication errors etc.

“It is difficult to manage so many patients with this ratio and this affects patient care. If I have to look after one patient in ICU I can take full and proper care of that one, but if I have three patients in ICU, then I cannot give full time to all the three, cannot give dedicated care and some mistake can happen” (N 8).

The nurses are expected to report for their duty on time and delay of even a few minutes leads to either deduction from their monthly salary or of a day's leave. While they are expected to start duty on time, they are rarely relieved from their duty on time. On an average, they need to fill and update 5-7 patient files,

hence they often stay back even after their duty hour to complete the paperwork and hand over to the nurse in the next shift. On the other hand, the team leaders need to complete paperwork for about 20 patients per day, as a result on an average they work for 2-3 hours after their duty hours, but it is not recognized as overtime (N1). The management considers 'double duty' as overtime and nurses are incentivized if they work for double shift. The respondents felt that if a nurse is assigned 2-3 patients, they can finish updating the patient file within half an hour.

Basic facilities at work: The respondents reported that during the 8 or 12-hour duty shift there are no assigned breaks for refreshment or for eating meals as hospitals are understaffed and they try to function with minimal staff. Due to the poor nurse-patient ratio nurses are forced to quickly finish their lunch or refreshment and report back for duty. If they sit down to eat their meal or have some refreshment, they are accused by their supervisors of not doing their duties.

Such experiences were more common among bedside nurses or nurses working in critical care department in comparison to nurses working in day care units, such as chemotherapy. There are no separate rest rooms for nurses where they can rest or have their meal, but in some hospitals, there were common cafeterias where nurses could have their meal.

“Between the 12-hours shift, there is no provision of refreshment by the hospital. And they ask us to eat quickly or get called on personal mobile or are physically ordered to report as soon as possible. We have to literally gobble up our food” (N5).

There are also no proper seating facilities for nurses in their nursing station and they have to often keep standing through the entire shift.

Respondents who reported having seating arrangement in their department said it is not adequate for all staff on duty and usually just 3-4 chairs are provided in the department, which are mostly occupied by the doctors. Therefore, nurses rarely get a chance to sit or rest in between their shifts. Most nurses shared that it is difficult to spend 8-12-hour work shift without taking any rest in between.

According to N1, “The 12-hours night duty is very hectic. When it comes to standing for long hours, (it is) difficult. Actually one cannot stand for more than two hours, it is extremely difficult to stand for the entire six hours. When it comes to ICU, there is no time to sit or rest, – yesterday I had 12 hours' duty, double duty. I sat for just 30 minutes in that entire time, because in ICU it was that busy. If the management provided proper bedside chairs, one can sit there and complete the paper work. If they provide chairs and other facilities, nurses will have the time to sit and take proper rest.” The respondents perceive that lack of space is not a reason for not providing such facilities for nurses; the management is simply not interested in providing chairs for nursing staff because it believes nurses are not supposed to sit during their shift. Some nurse respondents reported that sometimes the management provides chairs in nurse stations that are located at a distance from the beds, and the nurses cannot see their patients, making it impractical to sit in the nurse station when they are needed at the bedside. So, even if chairs are available nurses are unable to utilize them in the course of their duty.

Most private hospitals do not have assigned changing rooms or washrooms for their nursing staff. Where changing rooms are available, they are small and inadequate, there are no proper arrangements to keep their clothes and other belongings. The changing rooms at times do not have proper doors so nurses have to be cautious while changing. There are no assigned toilets for male and female staff. The toilets are cleaned once a day; since many staff as well as the patients' attendants use the same toilet, making it unhygienic. The work burden and time constraint hampers adequate consumption of water by nurses and makes them prone to contracting urinary tract infections (UTI).

3.2.3: Other employment entitlements and benefits

Provident fund, medical insurance

Provision of employment benefits such as provident fund (PF), bonus, medical care or medical insurance varies among private hospitals.

The big corporate hospitals provide certain benefits to nurse employees such as PF, gratuity, medical insurance and free medical care.

Some respondents said that in recent years, hospitals have withdrawn certain entitlement as part of a cost-cutting policy. According to OB 2, “Social security was there, but these benefits are being removed. Like the hospital where I am working, there was social security like medical insurance for the employee and dependent family members. But now due to cost cutting, no medical insurance is being given. There is no social security actually, in the private sector”.

Some hospitals do not provide benefits such as PF, rather they provide only a consolidated salary. “We do not receive any benefit other than our salary. There is no medical insurance, we don't get PF, nothing. The salary that we get in hand is all that we get from this hospital.” (N12).

Some private hospitals enrolled their nursing staff under Employees' State Insurance (ESI) scheme. Some big hospitals provide medical insurance of up to US\$ 2 706-4 060 (₹2-3 lakh) only for their employees, whereas in some hospitals the employees' family was also entitled to medical insurance. On the other hand, some respondents reported that they were not entitled to medical care or medical insurance from their own hospital, whereas some reported that their hospital provided partial medical coverage, in which they were entitled to certain medical care services and rest of the medical expenditure had to be met from their own pockets¹⁸. Nurses who received partial medical coverage from their hospitals were beneficiaries of ESI scheme and in case of any medical emergency they had to get themselves referred by their hospital to an ESI hospital for further treatment. This often led to; (a) delay in accessing care, (b) loss of leave and (c) unnecessary harassment. In such circumstances the nurses preferred to pay from their own pockets rather than being caught up in the process of availing medical care benefits.

Some private hospitals provided a special allowance called risk allowance for nurses working in high risk areas. The hospital may or may not give bonus to their employee. The respondents working in non-corporate hospitals reported not receiving any yearly bonus. However, respondents employed in big corporate hospitals reported that they were provided bonus by their hospital. “Those with salary above ₹21 000 (US\$ 284) get between ₹6000-8000 (US\$ 81-108). Those with salary less than ₹21 000 (US\$ 284) get good bonus - around ₹ 25 000 (US\$ 338).” (N13). Another nurse said, “There is annual performance-based incentive but . . . it is very little, and as for bonus, in my four years of job, I never got a bonus”. (N3).

Leave: sick leave, casual leave, privilege leave and parental leave - It appears that across private hospitals leave policies were similar. The HR department assigned a fixed set of paid annual casual leave (CL), privilege leave (PL) and sick leave (SL) to the nurse employees, but availing leave was not easy. The leave application is processed by the concerned nurse superintendents, and leave was assigned randomly, and not always based on request or leave application of nurses. Even for emergency purposes, the nurses face hardship in availing leave. It was reported that it is a common practice of management to not record the leave application submitted by nurses and mark them absent, thereby deducting a certain amount from their monthly salary.

The nurses were not able to utilize all their assigned leave, as the management deducted leave for reasons such as late arrival, or clinical/non-clinical errors.

Sometimes this mechanism is deployed to keep nurses under check, nurses who question/resist the decision of management or their supervisors often face hardship in availing their assigned leaves. “They say, 'Three months ago you were late so we are deducting three leave or you were late four months ago so

¹⁸The hospitals either provide medical insurance to their employees or deduct certain amount from their salary or they provide a lump sum to their gross salary and no medical care or medical insurance.

four leave will be deducted', and all this just because I questioned the management”, says a nurse. (N7).

All hospitals had the policy of providing sick leave to their employees. However, across hospitals availing SL was a lengthy process. In some hospitals if a nurse seeks to avail SL he/she has to come to the hospital to get a medical examination by the concerned doctor and then submit a leave application to the HR. Only when the leave is approved by HR department could the nurse take leave from work. On the other hand, some hospitals have made certification from an ESI hospital compulsory to avail leave. In either case a sick nurse had to run around for getting leave sanctioned before they could rest and recuperate. To escape such hassles, nurses adopted various mechanisms, such as (a) not availing ESI services, (b) continue working even during sickness or (c) they do not join work and accept deduction in salary.

“If we are sick, we do not simply get leave. For that we have to go to the ESI hospital, stand in the queue for 3-4 hours to consult a doctor, then again stand in the queue for 3-4 hours to get medicine, then come back to our own hospital to submit the letter. After this if the hospital permits you, then you can go home”, said another nurse. (N2).

The hospital provides parental leave only for their female nurse employees. All hospitals seem to provide nurses with six months of paid maternity leave. However, male nurses are not provided any such leave. They can avail 6-10 days of leave from their assigned annual leave, but this leave is adjusted by the HR department under PL or CL category. The provisions of parental leave in big corporate hospitals are better than non-corporate hospital or small hospitals.

As reported by the respondent, this policy has been recently adopted by the corporate hospitals since the court order on maternity leave entitlement. According to a male respondent working in a corporate hospital (N8), “We get maternity leave, paternity leave. One thing - corporate hospitals follow the government rules regulations and guidelines. Single management, small hospitals - these violate the rules - the corporate hospitals in Delhi give maternity leave for six months with salary; and paternity leave as per government guidelines. There was a court order three years ago - on maternity leave. Since then this is happening, not before that”.

Crèche facility is not provided by all hospitals. Very few respondents reported having a crèche facility in their hospital. But in some hospitals, the facility was exclusively for female staff and in others it was available for both male and female staff. Few respondents mentioned about the provision of 'nursing station or nursery' and assigned break for female nurse so that they could nurse their infants between their duty hours. However, since the start of the COVID-19 pandemic, all those hospitals that were providing childcare facilities had closed them down.

3.2.4: Harassment at workplace: lack of respect, low status

Harassment at work is a common experience of staff nurses - harassment from patients, colleagues and hospital management. There are various forms of harassment: mental harassment or bullying, physical harassment or violence and sexual harassment.

Mental harassment/bullying

Mental harassment is the most common form of harassment faced by nurses at workplace. Commonly known as 'clinical bullying', it is almost impossible for a nurse to complain, highlight or resolve this form of harassment. To some extent the professional hierarchies within a hospital makes nurses vulnerable to bullying, but often the hospital management subject nurses to mental harassment to keep them under control.

Shouting, scolding and insulting nurses on duty is a common approach of nursing supervisors. Nurses are made accountable for everything and blamed for any error that takes place within the purview of clinical or

non-clinical operations. As described earlier, nurses juggle the clinical care and non-clinical responsibilities such as, documentation, housekeeping, billing at discharge, patient food and beverages - all within their duty hours. Their engagement in the non-clinical activities restricts their complete involvement and proficiency in providing clinical care. Nurses are often assigned 7, 8 or 10 patients during one shift and hence are constantly at stress during working hours and at times some shortcomings take place. They are held responsible for everything, even for patient's mistakes or doctor's mistakes. The nurse managers and other seniors are also not supportive and shout and verbally abuse in front of the patients or attendants. "Everybody is scolding the assigned staff - other departments also feel free to scold them. It always happens - many staff are crying because patients, their relatives, doctors, in-charge - everybody is scolding" (N1). A male nurse in an FGD, said, "The way they talk to nurses is not good - at home one does not even speak to servants like this. They treat us very badly, their attitude is: "if you want to work, work, otherwise leave" - the attitude of the management is very bad, including MS".

When mistakes occur, the nurses are asked to give written explanation to the management. The management documents each error complaint and explanation letter, which is scrutinized at the end of each financial year during the appraisal of nurses. And employees having multiple errors in their service record can be denied increments or terminated from their job. "In the entire hospital you will not find anyone writing explanations as much as the nurses ... because nurses are obedient type of health care professionals, who are harassed and assigned extra duties. There is also favouritism in allotting duties, extra nights, workplace bullying. I have also faced it. But as I was in a senior position it was not that crude, but it was definitely there" (KI 3).

Interpersonal relationship between the nurse and their superiors is crucial to experience of mental harassment. Nurses who question or resist their superiors are often subjected to clinical bullying such as getting difficult or multiple patients with critical conditions, randomly assigned leave or refusal to assign leave as requested by the nurse. Other forms of harassment include assigning morning or evening duty to a nurse after completion of night shift, reporting to the management even minor errors and using the incident reports as a pretext of shifting a nurse to another department.

Some interviewed nurses highlighted harassment by their own nursing colleagues as well. Some nurses tend to align themselves with their seniors and management. Even serious mistakes of such nurses, who are close to their seniors, tend to get ignored. The respondents said their papers are never checked, it is not monitored even whether they are filling their papers or not. Some nurses said that good and dedicated nurses are also harassed for their diligence. When questioned as to why good nurses are harassed, one respondent explained that it happens due to lack of professional ethics and insecurity among senior nursing staff.

An intelligent staff makes seniors insecure and they feel threatened by such nurses, said KI 3. "My papers will be scrutinized until they find some fault in it. If I am writing 48-60 papers in six-hour duty for so many patients, there will definitely be some error. These will be highlighted at the higher level and I will be asked for a written explanation. On the other hand, there are people who please their seniors, and their serious mistakes are ignored" (KI 3).

Mental harassment is used by the management to prevent collectivization and also to ensure that nurses remain submissive. It was reported by the respondents that nurses who question the management are harassed by getting assigned difficult duties, deduction in leave and salary for minor errors, constantly scrutinizing their work and asking for written explanation, creating barrier in assessing entitlements or even withholding salary increments and promotions. According to some respondents, nurses feel helpless in such a situation, and find it difficult to resist or resolve harassment by the management as such behaviour by the seniors and management is not perceived as mental harassment.

Furthermore, employees who file a complaint are dismissed from their job, or singled out by the management; and any nurse or staff who sympathizes with the complainant faces clinical bullying.

"If the nurses complain, then the administration just terminates their services or takes action against them.

Such is the fear of management that other nurses working in the private sector cannot support the complainants. If they support them, then they are also fired” (OB 3 and 4).

The hierarchy between doctors and nurses also gives rise to some amount of harassment of nurses. In each hospital there are set tasks defined for doctors and nurses, but in many hospitals doctors put much of their work responsibility on nurses, such as writing the doctors' papers, taking patients consent for tests/procedures, sending samples to the laboratory, getting test reports, to name a few. Nurses are the only ones bearing the burden of documentation in case of an error or delay in treatment procedure or paperwork even if someone else is responsible. In such a work culture, nurses are not respected by their colleagues, doctors, or their superiors. As reported by the respondents, doctors treat nurses as their assistants where nurses are made to do many tasks which are a doctor's responsibility; so much so that doctors expect nurses to even pick the patients files for them.

Nurse respondents reported they are treated as assistants and often they have to keep chasing doctors for their signature to complete the paperwork. Often the doctors put blame of their errors on nurses and then nurses are asked for written explanations, another respondent said. “Doctors will blame nurses in front of everyone, verbally abuse and shout at nurses. That is a common practice by doctors, they consider us subordinate to them like we are their attendants.” (OB 2). Scolding nurses in presence of patients or patient's attendants creates a negative image of nurses among them and sends a signal that they can misbehave with nurses. When patients or their attendants witness bedside nurses being questioned for everything by their superiors or doctors, they perceive that nurses are accountable for everything.

In case there is a delay in any patient-related service such as, serving of daily diet, cleaning the patients, discharge process etc. the patients/attendants begin to misbehave with nurse on duty. “I think patients feel that they are paying so much money for their treatment so all their demands should be fulfilled. They automatically have this kind of mentality and so they always ask us to do various things for them. We don't have any choice . . . they always treat us like we are their slaves and they are paying us, so we have to do their work like servants”(N3).

Few respondents pointed out that since patients bear higher expenditure in private hospitals as compared to public hospitals, they expect good service, expect their demands to be fulfilled immediately. The respondents also reported of incidents where patients complain of delay in services and nurses are asked to provide a written explanation as to why management should not take disciplinary action against them. If there is a brawl created by patients or attendants, the management mediates only if the situation gets out of control of nurses. The respondents reported that the senior staff or nurse managers do not get involved as they consider abuse of nurses a common phenomenon. The respondents shared that management is not easily approachable and ultimately nurses are blamed for everything. Even if the abuse is initiated by patients or their attendants, still nurses are held accountable as the incidence took place during their duty shift; even if nurses are not at fault they need to submit written explanation to their superiors and management. “The management do not settle anything, rather they ask for explanation letter from us that this incident happened during your shift so why it happened in the first place? Why you did not do anything etc.? They will make us write a long letter and attach it to our feedback register. Then during appraisal all these attached explanation letters will be reviewed by the management” (N12).

Physical violence: Physical assault by the patients/attendants is another common form of violence that nurses face in their workplace. N2 shared an experience, “Once there was a case . . . it was a small matter, but the patient abused a lot, created a ruckus and even raised a hand on the staff. Immediately, the doctor, duty officer and management talked to the family, they had a meeting and said that they will file a complaint, 'It is better if the you apologize to the staff before the written complaint is filed. Then you can take a discharge and leave, we do not need such patients'. They did a lot for that nurse”. N10 also shared similar experiences, “Last year one of the attendants of a patient admitted in the ICU got into a physical fight with the doctors and nurses. They hit the doctor and held the nurses and threatened them. This happened late at night when neither the MD nor the NS was there. It becomes difficult to handle such incidents and they happen because patients and their attendants get impatient about services”.

“In the private sector the attitude of patients and attendants is that they are king. So if there is any delay in service from any of the other health team member they become very aggressive with us, even with the doctors; but the doctors usually put the blame on nurses and they escape the scenario. They are very aggressive, sometimes shout at us. Once an attendant threatened me and said that you are a woman that is why I am not shouting at you, otherwise I would have taught you (a lesson). Such problems disturb our mental health” (N5). Sometimes, the management supports nurses by mediating, but in most cases the management keeps aside the interest of nurses to please their patients. There are instances where even if the nurse is not at fault they are asked for written explanation or penalized, shifted to another department and could even face leave/salary deduction. “The nursing director said that 'though it was not my fault, the patient is customer here and we have to keep him satisfied and take some action, otherwise it will blow over’” (N13). In this case the nurse was not permitting a patient's relative to enter the ICU for organ transplantation and there was a heated exchange, following which he was threatened by the relative and a complaint lodged with the hospital. The nursing director asked this nurse to go on leave till the patient was discharged, but ensured that he got his salary.

Apart from violence by patients/attendants, there are also instances of physical assault by doctors or other senior staff on nurses. In such cases, the management usually supports the doctors and senior staff. As reported by the respondents, situation is better in the corporate hospitals where if a nurse complains against physical violence, the incident is investigated and the management tries to resolve the matter. In non-corporate hospitals no action is taken for violence against nurses if a doctor or senior staff is involved.

“In one hospital it so happened that a newly recruited nurse and the managing director (MD) of that hospital both were walking up the stairs. The MD slapped the nurse, saying that he was not given right of way.” (KI 3)

Several other practices seen as harassment by the hospital were:

- Assigning tasks other than what is mentioned in the job description: “they show something, but they give you something else” (KI 3).
- One female respondent (KI 3) said that one hospital she worked in, it was said, “it's ok if somebody does not know nursing, but I will not allow if someone is not good in physical appearance, or is not fluent in English”. So, selection criteria in some hospitals could possibly be looks and ability to speak English. Making a comment about personal and physical appearance of nurses at the workplace is another form of harassment.

Sexual harassment: Incidents of sexual harassment are not uncommon in hospitals. According to one male nurse (N9) patients' relatives behave badly with female nurses, calling them suggestively to other rooms, “In my ten years of service, I have seen this happen to other nurses many times. Some of the relatives sometimes call the nurses to other rooms, making suggestive remarks.”

It appears sexual harassment happens inside the hospitals because of the patients' relatives”. According to one respondent (N10), “It is completely up-to the nurses, if they want to file a complaint (of sexual harassment). Mostly the north Indian female nurses raise a voice against this. If there is a south Indian nurse, there will be a language problem. They find some difficulty in filing a complaint”.

Lack of respect, low status, lack of autonomy

Respondents having more than 10 years of work experience in private sector said that the work culture in private hospitals has changed over the past two decades. Since the 1990s, training and education in hospital administration and hospital management began to gain popularity.

Most big private hospitals began to recruit trained managers to look after health human resource, both doctors and nurses. Now the hospital management is handled by graduates from business schools and HR managers who are not familiar with nursing. In the “corporate culture” (a term used by the respondents) the management wields power over nurses. The respondents reported that nurses do not have work autonomy, they are not expected to apply their training or critical thinking - the management demands obedience and

compliance from their nursing staff. The management exercises control over the nursing staff through other nurses appointed to senior positions, who are paid much higher salary. According to KI 3 who left a big hospital after working for 13 years as a specialist nurse to join at a senior position in a corporate facility, “When I signed up for that position with high designation, executive, and so on, I thought that I will be doing so many good things for that organization. But after I joined, I realized that you are supposed to be a puppet. They wanted me to work on a fixed set of things, I was clearly told what I was supposed to do” (KI 3).

According to N7, “There are so many NS who are money minded, who want to exploit nurses just because they themselves will get a salary of ₹1-2 lakh (US\$ 1 353-2 706)”. According to another respondent (N5), “Nursing managers' attitude is in support of the management. They don't support the nurses even if they have genuine issues. So they maintain a communication barrier, are not approachable and fail to ensure the safety of nurses.

Nurses feel powerless to approach the hospital management because when they approach them to convey their grievances, the hospital authorities abuse and blame them. We will not consider discussing our problems with our nurse manager or the head because their approach to the situation is biased and they will ultimately blame us”.

The respondents perceive that private hospitals place high value on their doctors as they are the ones who bring business and profit, that the corporate culture has diminished the value of nurses and there has been a shift in the role of doctors and nurses in private sector hospitals. The private hospitals place doctors in front of the patients. This strategy facilitates hospitals in the competitive market where new business depends on how much care is provided by the doctor. “Because of the way the hospital structure has evolved in the private sector, the known star is the doctor. You go to a hospital not because you get good nursing care, but because of the name of the doctor or doctors on the case”. (KI 2).

The role of nursing professionals has got reduced to providing medicine/food to the patients, assist doctors in patient care and assist different departments in their work (lab, billing, housekeeping, nutritionist etc.) and documentation. Respondents felt that such additional work keeps nurse on their toes, therefore they are unable to engage in their actual role which is providing bedside care.

Patients/attendants think that nurses do not do any work; they do not respect nurses and do not comply with nurses unless the doctor asks them to do the same thing. “In a private hospital a nurse is given 4-6 patients and 3-4 hours of the entire shift goes in documentation, so they are actually not at the bedside. As nurses are not at the bedside of their patients, they think nurses do nothing, except are writing papers” (KI 3).

Some respondents felt that nurses are not valued within private hospitals. They are not treated with respect, not provided decent working conditions and they are discriminated against. Doctors do not consider them as team members but as assistants. “Doctors consider us subordinate to them like we are their attendants. Or we are their helpers which is not at all true” (N5). According to OB 1, “Corporate groups generally have the ambience of luxury, adequate supply, equipment, etc. But facilities for nurses, like continuing education and career progression, those are still less, except for a selected few who rise to the top and are appointed director of nursing or CEO or CNO. Most talented nurses are hand-picked and go to top positions now. CEOs in corporate hospitals are now nurses, or are vice president of hospital group – they are there. But that career growth is not uniform, salary is a major concern for beginners and those who are less experienced”.

The senior nurses are also under pressure to deliver results. Whenever there are some issues or errors in the department, senior nurse officials put the blame on junior nurses without any investigation and penalize them by deducting their leave, salary or asking for explanation.

None of the respondents reported receiving management support in terms of constructive feedback to help nurses learn from their mistakes, nor is there a system of employee feedback to understand the difficulties experienced by them or resolve them.

Nurses do not receive any motivation to excel at their jobs or encouragement to take up training/courses for skill enhancement. The respondents perceive that the management is not bothered about their problems and least concerned about their safety and physical or mental health, despite their hard work. This attitude makes them feel exploited at their workplace. “They (management) don't see nurses as a worker, as an employee. They are used as bonded slaves who can be beaten into doing work” (N7). According to N12, “If they feel that they also will be benefitted by resolving the issue, then they address it. But if it's only about a nurse's personal benefit then they will not support it. They will make the nurse run from one desk to another”. The reason for such attitudes was seen to be arising from the fact that nurses formed bulk of the workforce in hospitals. As their numbers are large, they are not considered employee or a professional, but as bulk manpower, says N5.

3.3: Occupational safety and health

In the context of safety at work, respondents described incidence of several health problems among nurses. Stress, back pain, UTI were the main problems - back pain due to prolonged standing; UTI attributed to poor water intake, working for long hours without a proper break. In fact it was pointed out that before COVID, the risk that most nurses faced was UTI, which was attributed also to lack of proper washrooms – “every floor has only one washroom and staff of all the three shifts used that one washroom”. Nurses were prone to illness due to lack of proper rest and food. Tuberculosis was common among nurses, and also infections acquired due to needle stick injuries (NSIs). There was frequent exposure to X rays and mental health issues due to stress. They were not able to get themselves evaluated in the OPD of the hospitals they work in because of lack of time. The families of health workers were also at risk of contracting diseases, such as COVID, causing the nurses further anxiety, according to N2.

Another nurse, N5 said, “In case of NSI, that can happen to anyone, the management or the nursing educator blame the nurses for not observing proper protocol, or their practices. Guidelines have been laid down by the WHO or Ministry of Health – such as after a needle stick injury we have to wash with soap and check the status of the patient. So nurses have to report it to their in-charges and to the medical officer, and get tested, take vaccine or any preventive drug. In this whole process of running around, nurses develop anxiety because if the patient is infected with an infectious disease like HIV or hepatitis virus, then they will be at risk for their whole life. After support is often lacking and in many institutions supplies and resources are lacking and the infection control departments are also not strong enough, and do not follow regulations”.

N5 also told us that sometimes patients are violent - especially psychiatric patients - there is also risk from patients with infectious diseases. There is no proof that we have fallen sick while taking care of the patients. So the hospital does not accept it as an occupational hazard or occupational disease. “Even in the times of COVID or such infectious diseases, they will say that we are giving all types of PPE and will never accept that it is an occupational hazard”, the nurse added.

At the time of joining the hospital, nurses are provided vaccination for hepatitis B and tetanus. The annual health check-up consists of X-ray, checking for fever, weight and height and Hepatitis B antibody test. Overall, the onus is on the nurses to stay safe and protect themselves while doing their work. During the online discussion on OHS, an office bearer said, “There are unidentified and not reported occupational hazards, due to the fear of losing one's job in private hospitals.

For instance, nurses are scared to report a needlestick injury or an encounter with infectious patients, because they feel it is not safe for them to tell that there is a problem. The moment they report it to the concerned authority, they might face some punishment because of the attitude that “it is your mistake”, instead of investigating the matter. No hospital would have a zero NSI, it is a matter of human error and has to be accepted, and nurses need to be assured of protection by the hospital and encouraged to report it and appropriate action need to be taken on the report. Not only do hospitals not compensate for occupational injuries, if an injury, such as NSI is reported, the nurse could be asked to resign to avoid paying

compensation. If the affected nurse seeks legal support, the hospital will have to provide compensation, which they do not wish to do”.

However, in some hospitals the situation appeared to be somewhat better. According to N10, “There is an infection control team and department. They make daily rounds. Earlier also (prior to COVID) we were provided gloves and masks, etc.” N3 too mentioned that even before COVID, they were getting masks, gloves, caps, gowns, etc. Similarly, N6 said that some occupational hazards are always there; but in her hospital “appropriate measures are taken in every case, including screening and treatment”. In N10's hospital, “If the nurses get any infection from their patients, then they get medicines free of cost. The serums or medicines are provided by the hospital. One or two years ago, a staff got infected, the injection for this infection was costly, around ₹60 000-70 000 (US\$ 812-947). Then the management arranged for the medicine and the staff got vaccinated”.

At the online discussion on OHS of nurses, a government official pointed out that in India “There is no systemic data or registry on prevalence of occupational health problems among nurses. Available data indicates high incidence of TB and stress. While steps were taken by the Ministry of Health to address the professional pathways, teaching and training in nursing, occupational health and safety aspects not only for the nurses, but for the healthcare workforce, have not been adequately addressed”.

It was also mentioned that “Very few hospitals offer medical insurance or free treatment to the nurses for illnesses arising from their work. When a nurse lands in any kind of difficulty or has any disease, majority of the hospitals in India force them to bear their medical expenses”. The private hospitals representative agreed that in the healthcare industry there is lack of awareness and focus of the entire leadership on occupational safety as a priority area. “Because of resource constraints, compromises were made in hospitals in areas of training or cost of providing immunization coverage to all nurses in the hospital, taking care of the occupational risks they have been exposed to and getting tests done”.

3.4: Gender issues in nursing

Gender, along with caste in the Indian context, has been an explanatory factor for the low status of nursing, poor working conditions, and discrimination against nurses in the hierarchy prevailing in the medical profession, as mentioned in Section 1.2.2.

According to N5, female nurses faced several problems. They were unable to use the restroom in time while they were menstruating, pregnant nurses were not moved to lighter shifts or units and some worked till full term with risk of contracting infections. So pregnant nurses were forced to quit their jobs. Though all hospitals have a maternity leave policy, many nurses do not benefit from it. It was reported by the respondents that while all hospitals have a provision for six months of paid maternity leave, often nurses are dismissed from their employment under the pretext of unsatisfactory performance as soon as the management gets to know about their pregnancy.

Such practices are more common in small hospitals and nursing homes, where the administration tries to evade the costs. The hospital managements adopt various methods to avoid paying salary during six months maternity leave, including terminating (without memo or notice) the service, or not renewing the contract of nurses, or by constantly harassing them so that they themselves resign from the job. According to OB 2, “They try to harass those who require maternity leave. They do not want to give maternity leave and benefits. That is why they harass the nurses and force them to resign. The smaller hospital also does the same. because, once they grant the maternity leave, they have to pay for six months, and they lose an employee. So that is why they exploit the nurses and they force them to resign and go”. N9 told us about the complaint that the union had received from a pregnant nurse who was asked to leave on grounds of unsatisfactory performance. Those who were confirmed and had documents could go to court, but those who were not confirmed, who were on probation could not do so.

Male as well as female nurses talked of resistance to employing male nurses in both private and government hospitals. Male respondents shared experiences of difficulties in finding employment.

According to N1, “The female staff nurses that too fresher, they might get job but for a fresh male nurse it was very difficult to find out a job. So, finally I came back to Pune and I tried to find a job in many places, but the major hospitals are not providing (employment to male nurses)”.

Most hospitals preferred female nurse staff over male nurses as they are seen as a stable, obedient and submissive workforce. It is easier for male nurses to get into a hospital through campus placement than otherwise. It was also reported that certain hospitals do not even call male nurses for interview. The male respondents perceive that they are seen as threat by the management due to their outspokenness and ability to give voice to their rights. Therefore, deliberately the proportion of male nurses is kept low in the private hospitals.

Even if the hospital is willing to recruit male nurses, there is a preference for a certain type of male nurses - those who are submissive. “If a male nurse went for an interview, they were instructed to keep their appearance simple and unthreatening. It was a standing instruction for interviews that ”you are not supposed to ask any questions if you really want to get selected”. Because if you ask anything you will not be selected” (KI 3).

A male nurse, N1 said, “Earlier, the female nurses were not that united. But ever since more male nurses have been recruited, the unity in the department has increased. This trend has been increasing. So the management feels that it will affect the entire nursing cadre and a united nursing workforce will become a force to reckon with. So they hesitate to take male nursing staff”(N1).

As described earlier, most male nurse respondents faced discrimination: one respondent (N1) vividly related that when as a fresher he was seeking employment in Pune, he had seen stickers in the hospital saying that male nurses are not allowed to enter for interview.

Another male nurse working in a tertiary level corporate hospital said he got the job after approaching the facility several times for interview, as there was reluctance to hire male nurses.

It is a well-established fact that in the workforce female labourers are employed wherever possible as they work for low wages and are certainly paid lesser than the male counterparts in violation of the Equal Remuneration Act. When respondents were queried whether this was the reason why female nurses were preferred to males, it emerged that there are no differences in the salary and employment and working conditions based on gender.

However, female nurses were provided with accommodation facility, whereas the male nurses were not, and had to bear additional expense of house rent and transportation, which forced male nurses to switch hospitals for better salary. One female nurse explained the reason for not employing male nurses (KI 3): “In the organization I was working, they preferred to recruit female nurses instead of male because they were scared of unionization. They would say these male nurses promote unionization and then there is threat of strikes”. She further observed that since the introduction of male nurses, the voicing of one's rights has assumed momentum. A male nurse (OB 4) explained that in the absence of specific job description or specifications for nurses, they are made to do all kinds of work. “If someone does not show up, then in their absence they will make us do whatever work is there. Now if they tell a male nurse to go do this work, he will say this is not my work and refuse to do it, while a female nurse will do it”. Male nurses were hired preferably in emergency and OTs. In one big corporate hospital of around 1000+ staff nurses, there were only 30-40 male nurses, mostly in ICU and Emergency sections.

Other office bearers too gave similar explanations for this resistance to employing male nurses: “When males started taking up leadership of trade unions, there was conscious effort by many managements to avoid employing males, as a preventive measure to avoid agitations. In any private hospital any employees' agitation is led by nurses, because they are the largest in numbers. Other employees - technicians, pharmacists, electrical staff, engineering staff, are negligible in number. But when nurses' union is formed, they also get the benefits. So many managements avoided giving employment to male nurses. In many public-sector All India Institutes, when number of males went up, they started questioning, arguing for the

nurses, which even the top government institutions did not like” (OB 1).

The government had taken a decision in 2019 to reserve 80% of the nursing positions for women and 20% for men in all the All India Institutes of Medical Sciences (Annexure 4 - Minutes of central institute body meeting, July 2020). This decision is viewed as a very retrograde step. The justification that female patients have difficulties with male nurses is not considered acceptable, considering that male doctors working in maternity or gynaecology wards are not considered a problem. “It is clear discrimination, If they fix 50:50 it is okay. If it was 80 % males, women would have problems with it. But 20% is horrible”, said one office bearer (OB 1). This order has been challenged by AIIMS nurses' union and others were also planning to take the legal route to end this sort of discrimination.

Female nurses view presence of male nurses as a positive development for the profession: “Many things seem to be much more comfortable and easy for us while dealing with patients; we can now call upon male nurses to attend to male patients. There are certain areas where presence of male nurses is useful, such as in ICU, where the position of critical patients has to be changed frequently so that they do not develop pressure injury in their body. Often patients are heavy, so I think it is good having a male nurse, they are physically stronger than you” (N3). It was also pointed out by some nurses that there were a few cases of male nurses who did not work properly or used their muscle power (OB 1).

Several reasons emerged regarding the passivity of women nurses or their failure to address the problems faced in the hospitals. Before males started coming into the profession, it was a fully female dominated profession. Some female respondents pointed out that women are trained to be obedient, to make adjustments, and therefore they made adjustments in the hospital setting also. Female nurses, mostly freshers, tend to keep quiet and they will be fine with whatever they get. “Female nurses do not complain, they are easy to impress.

For instance, management will give ice-cream to all staff. During COVID-19, the management gave the staff hand lotions, sanitizer, soap etc., with which female nurses became quite impressed and they overlooked the fact that US\$ 54 (₹4000) was cut from their salary (N13). It was also pointed out that as the females are mostly burdened with the household chores, after the duty they are busy with their family. They cannot spare time for association work. Women are the home-makers - most of the programmes are organized on Sundays, but Sundays as off-days, are the most difficult days for average woman of an Indian family (OB 1). In addition, they do not get permission from their families, they are afraid to comment on anything, so they do not participate actively in any issues in the hospital. The Indian reality is such that, whether they have a family or not, men get more time and more freedom and flexibility to travel, to spare time for organizational activities'.

The nature of nursing education was also cited as a reason for the inactivity of female nurses or their failure to stand up for their rights. According to one respondent, also a teacher (OB 1), in this country most of the institutions do not educate on how to be assertive, they try to educate nurses how to be submissive – noble character, disciplined nurse, those sort of myths are inculcated in nurses and they fail to assert themselves. They do not have to be aggressive, but they have to be assertive about their rights as a human being, as a woman, as an employee. Similar observations were shared by another nurse (KI 3) about how the idea of professionalism was missing in their practice or education; they were not well aware of policies and protocol; the education system 'did not make us good professional nurses they make us obedient nurses. We are taught from the start that seniors are always right, listen to your seniors, doctors, and just be obedient'.

3.5: Migration - international and national

The reasons cited by some respondents for international migration matched those noted by other researchers. According to OB 1, “Migration of nurses from India is a more than 50-60 years old phenomenon – since Independence. Migration is happening in large numbers now also. But the difference is that now percentage wise it is comparatively less. Earlier, if there were 100 nurses 70 maybe going. Now there are 1000 nurses only 500 may be going. That is because the opportunities are comparatively lesser”.

“The most important reason for migration is better working conditions - by salary and standard of living, but also by reputation and recognition nurses get, especially in the West. Going to Middle-east is basically for salary and short term assignment. Whereas when you go to, UK, USA, Canada, Australia, New Zealand, the work culture is quite different and nurses have more autonomy and are respected. Because so many nurses are going out of the country, there are candidates coming to nursing just to go out of the country because this is a good profession to migrate,” OB1 added.

However, with so many central government institutes - all India institutes have come up in so many parts of the country - many nurses opt for service there because the salary is good, there is job security and even pension after retirement. So, for these reasons, the number of migrations to other countries is reducing,” OB 1 said.

Several respondents were emphatic that migrations were happening because of the poor working conditions, poor status and lack of respect in the country. If the Supreme Court guidelines and other recommendations were implemented in India, if working conditions improved, then very few nurses would migrate. “If we get a good salary and good remuneration in our own country, who will choose to live in another country?” was OB 2's remark.

In N3's perception, “A majority of the nurses who tend to go abroad are south Indian nurses. I don't know the reason – it could be because in their native place they have relatives who would prefer if they went abroad”. N11 pointed out that, “Flying off to another country is not that simple - that you apply today and you fly tomorrow. They go through various processes; they need to complete various courses that is also an expense. And the processing charges and the agents take so much money from these nurses for arranging their migration”.

Migration within the country too was shaped by prospects of higher salary in cities like Delhi and Bombay, linked to the concentration of big corporate hospitals in these places, where the working conditions of nurses was relatively better than in smaller cities or in smaller hospitals.

Box 3.3: Migration from Kerala reducing

Movement of nurses from Kerala has received a lot of attention in the discussions on nursing workforce in the country, as mentioned in Section 1.2.3. Findings from a recent study on this phenomenon of international and national migration from Kerala indicate that such movement had reduced in the last few years. The observations made by some respondents match these findings. According to N10, “Now there are very few south Indian nurses in Delhi. When I had joined (2008), there were 28 staff out of which 8-10 nurses were north Indian staff and rest were from southern India. Earlier, there were not many nursing colleges here, so most people would go to Kerala, Karnataka and Andhra Pradesh for nursing degree. Now so many nursing colleges have started in Noida, here in BH hospital and the nursing college in Bahadurgarh. So the staff is recruited from these colleges, such as in the Hospital in Dwarka. These institutes also advertise that they give 100% job placement. With nursing colleges being opened in North India, people from the North are getting training in these institutes and are being recruited, so less nurses are coming from South India. The management is advising less recruitment of nurses from South India and more from the North to avoid the language problem. It is felt that in case of a conflict with the patient and attendant, if there is a complaint then it becomes easy with North Indian nurses. The management needs to satisfy the patients and attendants. So, they prefer staff from North India. One of my acquaintance who went for interview was told, 'if you are fluent in Hindi then you can appear for interview'. Due to all these reasons, nurses from South India have reduced in my hospital and a smaller number of fresh graduate nurses from South India are joining here”.

Section 4

Findings and discussion 2

4.1: Grievance redressal

As described in an earlier section, several respondents and key informants described a range of harassments faced by staff nurses from their superiors and management. In their experience, such harassment happened more in the non-corporate hospitals. Some corporate hospitals had some procedures to deal with cases of harassment and thus avoid escalation.

However, the functioning of the procedures is not very satisfactory. The observation of N3 was, “There is a process. If we want to complain, first we have to go to our nursing head. After that the complaint will get escalated to a higher level - like HR - the higher authority. The HR person often asks the nursing head to 'sort out or suppress the complaint at your level'. They want our department head to do it; HR does not take any direct complaint from us”. N1 also explained, “There is a system - filing of incident report, which is analyzed by a Root Cause Analysis (RCA) committee. This committee investigates the incident and if deemed necessary, can ask the nurse for a written explanation. A show-cause notice is then sent to the staff, who have to give written explanation about why disciplinary action should not be taken against them. But largely, this system is bypassed by the administration and nurses are directly asked for written explanations for minor errors, often not related to their clinical responsibilities”.

N1 further said, “If they follow a proper system, there is a chance to explain yourself. If I have done something wrong, made a mistake, then I can explain through the explanation letter. But if I haven't done anything wrong and yet I am coming under the culprit book, that is wrong no? That is why, first you have to raise the incident, then you have to do the RCA and only if the staff is wrong, you are supposed to ask for explanation. Often, the immediate in-charge handles all these issues, the ground level issues mostly do not go to the management, which is also not interested in listening to the nurses - because they are in such large numbers (in any hospital). The management does not settle the issue, rather they ask for explanation letter from nurses, on the pretext that 'this incident happened during your shift so why did it happen in the first place? Why you did not do anything etc.?' Without proper incident raising, RCA, if you keep writing explanations, it can affect the job as it directly links to the appraisal. The letters by nurses are attached to their feedback register. The in-charge keeps a record of all the explanations written by nurses. Then during appraisal all these attached explanation letters will be reviewed by the management. If my in-charge does not want me to work in his department due to some other problems - maybe personal, maybe attitudinal – transfer or even termination can happen”.

Pointing out or raising any issues or problems could potentially lead to victimization, as suggested by N11, “One will not find conditions like these in government hospitals. Salary is one - there is difference in salary, then there are allowances, cadre is secure in government hospitals. Whereas, even though we are secured, management can take any action against us, but this is not possible in the government sector. If there is some medical negligence, it's different. But if we highlight some issue to the management about the lack of facility or something wrong happening, the management will make a note of this and see how to take action against us in future. The complainant of such issues is marked out and they will try to remove that employee”.

The nursing supervisors and managers were not approachable, and even when apprised, were not helpful or forthcoming about resolving the problems of nurses. On the contrary, they often downplayed the issue and passed the blame on to the nurse and find fault in her behaviour.

According to N5, “We do not consider discussing our problems with our nurse manager or the head, because their attitude is not supportive and will ultimately blame us. They fail to motivate their staff and there is always a communication barrier. They are not very successful in ensuring the safety of nurses”. Some doctors have also drawn attention to such practices in private hospitals, “It is common to find nurses in workplace being treated as doormats. Being shouted at by doctors - who bark orders and reprimand them during rounds in front of patients - is common. Their superiors like nursing superintendents and supervisors, who are supposed to stand up for their cause, most often turn against them, supporting policies detrimental to their welfare to win favour with hospital management” (Jacob 2020).

The practice of victimization appears to be so widespread that the NABH Nursing Excellence Standards has guidelines addressing them (NABH 2013). NRM 8 on workplace safety for nursing professionals, recommends that “management shall ensure that there is a mechanism whereby any safety related issues are duly reported, shall endeavour to promote a culture of reporting safety related issues so that there is no victimization; that the nurses are educated about their rights and the head of the nursing service protects nurse (s) rights”.

As mentioned earlier, in Section 3.2.4, sexual harassment of female nurses is given attention and addressed by the management, and appears to be lesser in recent times, with hospitals coming up with policies and protocols. Several respondents reported having Prevention of Sexual Harassment (POSH) committee. If a female nurse is abused or harassed they could file a complaint with the committee.

According to N2, “In our hospital there is a committee for sexual harassment. We can complain there. The management of our hospital is in our favor in this regard. Whether male or female, in matter of sexual harassment or misbehaviour by the patient, the management is in our favour. They conduct inquiry, if they need to discharge the patient or if they have to go to the police, they will even do that. They do not back off in these matters, I have seen this”.

“There is a POSH complaint number in the hospital to report cases of sexual harassment. If a staff is harassed by a patient or attendant or doctor or anyone else, they can call that number. A 7-member POSH committee takes it up. For instance, there was the case of a staff who was abused by a doctor. She complained to the POSH committee, the doctor had to give a written explanation and apologize to the staff. This does not happen in non-corporate hospitals – there, even if a doctor hits a staff, nothing will happen; the management will take the doctor's side and no action will be taken” (N8). However, the POSH committee is often steered by doctors or senior management, and rarely has a nurse representative.

There are hospitals - generally smaller ones – that do not have a functional POSH committee. Some of the policies are just on paper, to be placed before the external audit in such hospitals. The committees in some hospitals are not functioning properly and there is no employee sensitization on gender and gender issues. Only one of the respondents shared that initiative is taken by HR to train and sensitize nurses on issues such as sexual harassment. However, in most cases instead of following the procedure through the POSH Committee, the management tries to suppress or resolve the matter internally through a settlement between the two parties, wherein the nurse who has been harassed is given an explanation or written apology by the person who harassed her. The violator is not punished until the nurse seeks justice through court. As N9 said, “Some policies are there only on paper, to just show to the internal or external auditors.

If a nurse complains, she will be told to save the hospital. “Okay, you don't want to complain, we will sort it out internally. We will talk to that particular person”. The female nurse, invariably cannot say anything and the management will save that person who has harassed her. So there will be the policy, protocol, everything, but nothing is being taken care of by some managements. Only if the nurse comes out of the hospital and goes to the police or the court will action be taken against the harasser.

Presence of associations and unions in some hospitals also helped to raise the issue with the management or in the court. However, seeking justice through court or unions/association is not an easy option to take for female nursing staff, as they are either dismissed or harassed to the point that they themselves resign from their job. “Earlier, sexual harassment was very common because of the patient' attendants.

Nowadays we have a union, so nurses can open up to the concerned persons, or the court, and the hospital too has introduced different types of policies and protocols. The hospital has framed the policy after intervention of the Women's Commission”, says N9.

Interventions, negotiations by associations or unions

In private hospitals, the head of the institution who is responsible for the welfare of nurses and labour courts can take action on cases of harassment and violations of entitlements of nurses. Nursing associations and unions take up such individual cases when approached by the nurse. They write to the management and try to resolve the matter. The number of actual incidents of harassment and violation is much more than those taken up by the associations, courts etc. According to one office-bearer (OB 1), “there were many cases that could be taken up, but the number of actual incidents and cases where they get involved and settle are relatively less - 'it is a negative balance'. This is because many times the concerned nurse withdraws the complaint, which fails us also because we are not able to proceed. The number of violations, complaints of harassment (that) come out are comparatively less. That's because nurses usually do not come out and complain or follow up the case. If they make a complaint, after some time they may withdraw it. Many times they say, 'I don't want to proceed with this issue because I am going for another job, I want to just resign and go'. That sort of inhibition is very common among nurses”.

Such withdrawal of complaints has a negative impact on the unions which are fighting their case with the management or in courts. “If the person who is affected, does not want to move forward with the complaint, we cannot take up the issue. The management says 'she doesn't have a complaint, what is the issue?’”, says OB1. Another respondent, also an association member, shared similar problems - of unwillingness of female nurses to complain or follow up on complaints. Says N10, “Most of the nurses are female so they don't want any trouble with the management. Even their families pressurize them and say 'whatever money you are getting, take it and come back'. Moreover, the complaints procedure is very long and stressful for the nurses - they have to gather information, visit the labour office and do constant follow-up along with their nursing duties. It's a long process. So most of the ladies do not want to make an issue of it”, N10 adds.

When any association of nurses takes up their complaints and approaches the management, the response of the private hospital management is generally defensive. An office bearer (OB 2) explained that “they try to defend themselves or deny. The usual mechanism is first they will deny the issue at all, but when presented with evidence, then defend themselves by bringing up the financial difficulties and finally, try to put the blame on the complaining nurse.

However, not all hospitals give a negative response. Some try to cooperate and settle issues when the nurses' organization approaches them. According to one office bearer, 'Professionally managed groups are comparatively better - whatever is the issue, it is not good for their name and fame, so they usually cooperate with us when we go as an organization. But in most private hospitals, there is no internal grievance redressal mechanism, even government hospitals do not have them.

On paper some redressal mechanism is there, but it is actually not working in a majority of hospitals. That is why we have to usually intervene and try to help the staff. In pre-COVID time when we tried to intervene in some harassment cases, the hospital would try to settle within themselves and say there is no complaint. Some hospitals settle issues so that their reputation is not impacted”.

4.2: Collectivization and social dialogue

4.2.1: Unionisation at the hospital level and barriers to the same

The presence of an organization of nurses and that of its representative in the hospital gave confidence to

some nurses to seek relief from the harassment that they faced as described earlier. According to OB2, “If there is any harassment, this (nurses' organization) committee will get involved. We have a power that is a union power, that is the reason why they [management] are not harassing (nurses). Some forms of harassment have reduced and overall there is considerable reduction in harassment because of the involvement of the association” (N11).

Another respondent expressed how being part of a nurses' organization gives her confidence to raise her issues. This is particularly important as many respondents referred to the inhibition female nurses feel in raising their concerns. “The management called me and I was asked to submit a written letter of whatever problem had happened to me. I said, 'sir if I write everything in the letter then I will also submit a letter to the committee (nurses' organisation),” said N2.

The lack of the presence of an organization of nurses was highlighted as a setback in making nurses' voices heard. Respondents said that management often played deaf to their individual complaints, including for collective issues, and that coming together as a group was an important step in ensuring that they were heard. During the FGD, nurses mentioned that “Initially staff were sending mails individually. They [management] did not reply to them. [...] They did not reply to those who had sent mails personally. When we got together, prepared an application, signed and sent it, then we got a reply”. However, respondents also said that a collective voice might not be enough, and nurses are sometimes forced to undertake collective action, including mass leave or strike for more systemic change at the workplace. “After the protest, they provided water, changed the PPE, demarcated proper donning areas and automatic sanitizer machine. Within one week of filing the petition, things started getting viral, media started coming. After that they started providing these things,” (FGD).

Hospitals discourage collectivization by resisting employing male nurses as discussed earlier. Other steps were also taken to prevent nurses from forming associations and unions.

According to N10, “If we are in some union or work in an organization, they will keep our name in the hit list. They will think about how to cover up, how to settle score etc. Some nurses do not want to tell their issues in the group as their supervisors are also part of that group and sometimes they have issues with the supervisor. Then we have to mediate the discussion between the staff nurse and in-charges. We also give information about our meetings in the social media, so obviously management comes to know who all are there, who all encourage staff to raise their voice. The management is scared of such activities, so they keep tabs on us. They even tell notice us and later if there is any issue, they call us that 'you are a big leader, you instigate the staff etc. They will not tell us directly, but they will tell our HOD, in-charge, superintendent to control us, saying 'he has started speaking much. Keep a watch on him'. And they keep a close watch on the activities of the union members and pull them up for even the slightest issues, such a late arrival.”

“They also try to brainwash us by saying that 'if you are working as a union leader, the management will keep an eye on you. So, you should not go with union or any organization. It is better for you to do your duty and go home.' It (association with union) does not affect the increment, but it does affect our workload because the management, superiors often increase our workload if we are associated with a union.”

In one corporate hospital, when the nursing director (ND) got to know that a certain organization was establishing contact with the nurses, each of the nurses was summoned by the ND and told that if they wished to retain their employment in the hospital they could not join that organization. In addition, “male nurses are invited by management from time-to-time and kept entertained with parties etc., to keep them happy, to prevent unity among the nurses”, said N13. He also said “(Nurses are) not allowed to form associations, no unity is allowed. When an organization sent messages on phone, came to talk to nurses, the supervisors got to know; they called each nurse individually and warned everyone they would be asked to leave.”

“When I joined the organization the ND called me and asked, 'why have you joined the organization? you are earning well.' I gave the ND the example, where with the support of this organization, the nurses

launched a struggle and were successful in getting their salary raised from ₹3000 to ₹20 000 (US\$ 40 to 270); they have done well for nurses so I decided to take membership,” said N13. When asked how the management gets to know about such matters, we were told that there were people among the staff who inform.

The most common action taken against those who are part of unions or take up the cause of the nurses with the management and initiate union activities are: a) dismiss them, b) refusal to give experience certificates at the time of leaving, or mentioning their union activities in the certificate, c) taking written guarantees at the time of joining that the nurse will not join any association or union, d) making their work conditions more difficult so that they are forced to resign. Giving the example of one corporate hospital, a respondent said around 70 nurses went on a strike, demanding increase in salary, increments and work facilities. They had given a representation to the management to which there was no response, hence they went on strike. The management arrived at a compromise, but it cancelled the contract of one nurse because he/she had participated in the strike and management mentioned that participation in the experience certificate. Similarly, in another hospital the management cancelled the contract of 3-4 staff that had participated in a strike. The other strategy is to shift staff that takes initiative or participates in some collective action from one department to another. After working for a few years in one department the staff learns the work there, gains experience and works well, they are then shifted to another department with difficult work. If the staff refuses to shift, the management will say, “then you resign and go” (N8). Such practices are prevalent in all private hospitals, whether corporate or non-corporate. Several respondents were quite emphatic that in all hospitals if a staff comes with some demands then the management will find some pretext to remove them from the hospital. “If they get an opportunity, then they will definitely remove them” (N8).

Another practice is to pay different salaries to staff recruited at the same time, in same area also, and thus create rift among nurses by preventing any unity among them. Staff members who support others who complain or raise such issues will also be fired. “So even if there is good relationship and rapport among staff, they can't support, as they will also get fired”, said an office bearer (OB4). Nurse representatives point out that none of the hospitals, especially the private ones, want to have a nurse's union in the hospital as they perceive it as a threat and a disruptive practice when nurses demand their rights. As a nurse union leader shared during the online panel discussion on WPSD, when nurses approach the hospital management for a meeting, it is often viewed as a fight scenario by the latter, and the nurses mostly end up facing rejection. What is rarely considered is that asking for a meeting with the management can also mean that the nurses wish to convey some message about issues that the management has failed to address.

Apart from such employer practices to deter unionization, other challenges to collectivization were related to factors such as the gender composition and its impact, as discussed in Section 3.4. It was also pointed out that as the female nurses are mostly burdened with the household chores, after the duty they are busy with their family. Sparing time for association work was difficult. In addition, they do not get permission from their families and they were afraid to comment on anything. So they do not participate actively in any issues in the hospital.

The Indian reality is such that, whether they have a family or not, men get more time and more freedom and flexibility to travel, to spare time for other activities, such as participating in nursing organizations. Such challenges have been identified by other researchers, as discussed earlier on in Section 1.2.6.

What emerges is that nurses in the private hospitals in Delhi find it difficult to form associations and unions, or to get openly involved in unions.

4.2.2: Elusive social dialogue

Social dialogue is defined by the ILO to include all types of negotiation, consultation or simply exchange of information between, or among, representatives of governments, employers and workers, on issues of common interest relating to economic and social policy. It can exist as a tripartite process, with the government as an official party to the dialogue or it may consist of bipartite relations only between labour and management (or trade unions and employers' organizations), with or without indirect government

involvement. The main goal of social dialogue itself is to promote consensus building and democratic involvement among the main stakeholders in the world of work. ILO identifies that in addition to strong, independent workers' and employers' organizations, political will and commitment to engage in social dialogue on the part of all the parties, as well as the respect for the fundamental rights of freedom of association and collective bargaining are necessary enabling conditions¹⁹.

The study findings point to a ground reality where social dialogue is difficult. On one hand, management of hospitals do not easily acknowledge the role of nurses' organisations as interlocutors, and rather tend to actively engage in destroying them. "The administration will not entertain any unit. For example, if we have some issues in our unit, they will not call us and address them. Secondly, they do not allow any associations to work there. That means in the hospital right now, we are not allowed to form a union. Like people were removed [terminated]. There are several examples" (OB3, OB4).

On the other hand, respondents also said that nurses organisations have to force the hand of hospital management to enter into negotiations by resorting to industrial actions and involve the labour conciliation machinery. "We had strikes in three hospitals. After an 11-day strike in "M" hospital, we signed the [negotiated] documents in front of the labour officer. In "B" hospital again after a 10-days strike, we involved the labour department and the labour commissioner. And, in front of the joint labour commissioner we signed a [settlement] agreement. It's all collective bargaining", according to OB2.

It was also mentioned that while a negotiation might have succeeded, the individuals involved might still be targeted and face retaliation personally and professionally after the collective issues are resolved. This points to an engagement in bad faith in the social dialogue process. "They [the management] accepted half the demands, but after that when everything was normal and they [the nurses] have again started work in the hospital, the management picked on every nurse who was involved with that strike or protest. Eventually, they had to resign from their positions", according to N3. "The management came to a compromise in the labour court. They renewed the contract of one staff, but because the staff had participated in the strike they cancelled that contract. And in this case too, the management mentioned in the experience certificate of that the staff had participated in a strike. Similarly, in "A" hospital the management cancelled the contract of 3-4 staff that had participated in a strike", said N8. It is a worrying trend that even if collective action brings an improvement to the working conditions of the nurses, a few individuals still have to pay the price personally.

From what respondents shared it is clear they have to face a hostile environment in which forming a nursing organisation has to be hidden, until the organisation is strong enough to withstand the management's backlash. "See, here if we make an association, and there are ten people in it, and these ten people raise their voice against the administration, they [the administration] will terminate those ten people. [...] they will simply remove all of them and recruit new people" (OB3, OB4).

As engagement in good faith by management in social dialogue at the hospital level is lacking. Nurses organisations are pushed to take more confrontational approaches, including strike actions, to ensure that their issues are heard and resolved, if need be, in the labour conciliation office or labour courts. The more confrontational nature of social dialogue in private sector nursing creates an additional barrier to women's role in the leadership of nurses' organisations. The nature of social dialogue means that organisation leaders are given more visibility, including in the media. Said a nurse respondent, "(female nurses) are ready to struggle in their department, in their hospital they are ready to complain, but at a big stage they don't want to come forward". (N3)

4.2.3: Collective momentum in private health care sector for regulation of working conditions

The private health care sector did not have a tradition of collectivisation of the nursing workforce, in contrast with the situation in the public health sector where there are active nurses organisations since the late 1970s at the state and national level (Basu 2016).

¹⁹[%20%20a](https://www.ilo.org/ifpdial/areas-of-work/social-dialogue/lang--en/index.htm)

As discussed in Section 1.2.5, after mid-2000 the situation changed and several unions and associations emerged among nurses in Delhi and Kerala, which took up the problems faced by nurses in private hospitals, especially that of the poor salary in absolute terms and as compared to nurses in the government sector.

One significant outcome of these movements of nurses was a petition in the Supreme Court of India for regulation of working conditions of nurses in private hospitals, the genesis and trajectory of which is described in the following section.

4.3: Regulation of salary and working conditions

4.3.1: Poor remuneration in private hospitals - interplay of policies, gender, changes in private health care sector, historical attitudes and practices

What becomes clear from the above discussions on employment and working conditions of nurses in private hospitals in Delhi is that while nurses face a range of harassments, challenges and problems at work, low salary/remuneration is the main problem, whether it is in big corporate hospitals or the non-corporate big and small hospitals and nursing homes.

Several facets emerge about this issue of low remuneration in private hospitals:

- The salaries paid currently are way below that of their counterparts in public sector hospitals
- Even within the private sector there is variation, with small hospitals paying lower than the ₹20 000 that is the starting salary or minimum paid by some of the corporate hospitals.
- The remuneration does not commensurate or bear relation with the fact that like doctors, nurses constitute a trained, skilled professional workforce, after going through the rigours of nursing course for four years and some also pursue further specialization.

As rightly pointed out by one of the lawyers (KI 1), “Minimum wage is actually laid down for a daily wager or a labourer. A labourer who is doing a physical job without professional qualification is getting a minimum wage, but a nurse who is a professionally qualified is not getting even the minimum wage. Actually, nurses do not come under the area (scope) of minimum wage, they are professionally qualified people, so their salary should be much above the minimum wage”.

The study provides some fresh insights into this situation of low salaries of nurses in private hospitals and the attention to it by nursing associations over the past decade.

The private sector in India for a long time has comprised small hospitals and nursing homes, with many being non-profit (missionary or voluntary); it is only in the past two decades that there has been growth of a for-profit, corporate sector and setting up of large hospitals in metros as well as tier-2, tier-3 cities (Biju 2013, Hooda 2015).

In this scenario nursing was viewed largely as charitable or missionary work, done predominantly by women. One office-bearer (OB 1) explained, “Whenever this issue of salary of nurses was raised with the management, it was framed as charity work- at the same time they were paying doctors huge amount Secondly, for several decades nurses working in private sector were also seeing this mostly as a temporary or transit job, on the path to a good job in the government facility or in some foreign country. So, generally they didn't focus on working conditions – though they would complain, they would not take it very seriously, because they were there for a maximum period of one to three years. After 2005-06, migration of nurses to the Middle East as well as to countries like the US and UK suddenly reduced. There was global recession, local people were being trained in the Middle East and western countries and governments there were promoting nursing employment for their own citizens. So job opportunities for nurses from India reduced”. These observations match the observations made by others, as discussed in

Section 1.2.5, and the figures on international migration, discussed in Section 1.2.4, showing a decrease in migration from Kerala.

At the same time, Indian government policies of promotion of skill development of youth to promote self-employment through the National Skill Development Corporation (KPMG 2013), along with policies to address nursing shortages by encouraging private sector to step in led to spurt in private nursing colleges being set up around late 1990s and 2000, especially in southern states like Kerala, Karnataka, Tamil Nadu, erstwhile Andhra Pradesh, and Maharashtra (FICCI 2016, KPMG 2013).

There was also encouragement of private health care sector in general and forecasts of boom in medical tourism and in the health care industry in general, and hence increased demand for health care workforce (ibid.). There were changes in the private health care sector too, with trend towards corporatization and setting up of big, specialty and multi-specialty hospitals, as mentioned above. One respondent (OB 4) told us about how they had heard of INDIA VISION 2020 by then President Kalam in which health care was projected as a rising sector and believed that nursing was a promising profession. Together, such developments led to young people joining nursing, with the belief that employment prospects were good, the government salaries were also good, and there were chances for going abroad. Nursing became an attractive career option and a means of social mobility for many (Johnson et al 2015), with men also increasingly coming into this profession as our study clearly indicates.

By then, however, the demand overseas was not as much as it was earlier. The governments too were not setting up as many new hospitals, given the policy of increasing privatization of health care and decreasing health care budget.

So, nursing graduates were compelled to seek work in the private hospitals, at whatever salaries were offered. This issue was faced by several of the male nurse respondents in this study. As summed up by OB1, “There was surplus supply of nurses, and market forces came into play then to keep salaries depressed and nurses often agreed to whatever were the working conditions”. Nurses were finding it difficult to get jobs, getting stuck for 5-6 years, and the future was not as rosy as it had been made out to be but. In fact, it looked difficult and uncertain. Few years after graduating, the reality of the employment scenario and conditions in private hospitals became evident to them – that of inadequate salary and multiple problems at work.

4.3.2: Collective action translated to legal steps and more

It is in such circumstances that around 2010 there were strikes and agitations by nurses in the three metro cities of Kolkata, Mumbai and Delhi, as described by some office-bearers in our study and discussed in literature (Section 1.2.5). According to a respondent, “There was a strong nursing movement for the first time. Mainly nurses from Kerala started an agitation – it was a spontaneous movement and there was no organized structure. In one or two hospitals, nurses started boycotting their job and sitting in protest in front of the hospitals. It got media attention and backing from political leaders in Kerala, with a Member of Parliament visiting them and pledging support. Soon it became a movement and there was unrest in various parts of the country. Though none of these efforts achieved a conclusive win or result, the issue of salary and working conditions of nurses came into the public domain and gained some prominence”.

Out of this spontaneous movement emerged organized structures of collectivisation, such as Indian Professional Nurses Association (IPNA), Delhi Private Nurses Association (DPNA) and United Nurses Association (UNA). These organisations raised demands such as better working conditions for nurses through agitations, legal mechanisms, pressure on professional bodies of nurses and advocacy with elected representatives. As a result, in July 2014, a set of questions were asked in Parliament to the Ministry of Health and Family Welfare (MoHFW) regarding its response to the issues raised by nurses. The government then made a commitment to improving the working conditions of nurses (see Box 4.4).

**Box 4.4: Low salary and poor work conditions
of nurses in the private sector raised in Parliament**

On 18 July 2014, the following questions were raised in the Parliament to the Minister of Health and Family Welfare:

- Whether the Government has taken note of various agitations and representations made by nurses and nurses organizations in the recent past, seeking improvement in miserable working conditions of nurses, particularly in private hospitals across the country and if so, the details thereof;
- Whether the government has received any complaints regarding treatment of nurses as bonded labourers, payment of low salary, long working hours, lack of medical facilities, demand of sums for job placement abroad etc.;
- If so, the details thereof and the action taken/proposed to be taken by the government against the erring institutions during the past three years and the current year;
- Whether the government proposes to bring a uniform policy for state as well as private hospitals to fix minimum wages and working hours for nurses and to improve conditions of nursing professionals in the country;

If so, the details thereof and if not, the reasons therefore.

The Health Minister's reply to the above was as follows: The matter pertaining to improving and regulating the service conditions of the nurses working in the private hospitals in the country comes under the purview of the state governments in which the private hospitals are located. However, on the basis of matters raised in the Parliament, the debate in Public Interest Litigation Writ Petition No. 430/2011 in the Hon'ble Supreme Court and references received from various sections of society, all the state governments have been requested, vide letters dated 7 July 2010 and 24 February 2012, to take necessary measures for enacting a comprehensive legislation for improvement of service conditions of nurses, including those working in the private sector.

Further, Indian Nursing Council has taken initiatives and issued a circular on 23 September 2011 to all the state governments, stipulating that if the unethical practice of obtaining service bond/forcefully retaining the original certificate of the student comes to notice then in that event, penal action would be taken against such erring institutions
(<https://www.indiannursingcouncil.org/pdf/bond.pdf>)

By 2010, a century-old, established professional organisation of nurses, the Trained Nurses Association of India (TNAI), which was till then largely engaged in welfare and educational activities among nurses, was compelled to pay attention to the issues being raised by the agitating nurses, including their own younger members, about the poor salary and working conditions.

According to OB 5, “We are active with educational activities, like quality improvement activities, welfare activities, but whatever said and done, the most important thing about a profession or a job is their earning and living conditions. Without improving that directly nothing is very meaningful. While the general attitude of TNAI is that nurses should not resort to strikes because it is a matter of human lives, yet in a democratic country like India, there are ways of raising their issues, supporting, lobbying, and advocating for them”. In December 2011, TNAI filed a civil writ petition (WP) in the Supreme Court under Article 32 of the Constitution of India, for safeguarding the life and liberty of nurses working in hospitals/clinical establishments and to improve their working conditions. The respondents were the Union Government of India and nine other state governments. OB 5 further adds, “As there was no continuity of the agitations, but as the issue had come into the public domain and was highlighted in the media, TNAI thought that this was the best time to approach a legal authority to bring some justice to nurses. That is why we went to the

Supreme Court, with all the media reports and photographs of strikes.” The IPNA had also gone to the Supreme Court on the issue of wages and working conditions of nurses, but their petition was not admitted by the SC on the grounds that it was not for Supreme Court to deliberate, and they should go to the appropriate labour court. TNAI had avoided this issue by asserting that they were “not a trade union, that they were working for the welfare of the nurses as well as for the welfare of society”, said OB 5. They framed the problems of the nurses as an issue of public health and public welfare: “if adequate remuneration and satisfactory living conditions were not provided to nurses, the health care of this country would be affected, as no-one would join nursing and there would be a shortage of nurses”, OB5. The SC admitted the petition by TNAI as an issue of importance to the health of the people. However, TNAI believes, “if these agitations by nurses had not occurred, the TNAI petition too may not have been heard by the court”. (OB 5).

The prayer in the TNAI petition was: to issue guidelines for improving the working condition of nurses in hospitals/nursing homes; to direct the respondents to adhere to the guidelines/rules framed by the SC till necessary legislation was made by the central or state governments.

TNAI also petitioned the court to issue necessary directions to ensure that nurses working in the private sector were paid salary equivalent to salary given to nurses in government hospitals and to issue a declaration that the bond system practiced by hospitals/nursing homes is unconstitutional and illegal (Annexure 5).

Five years later, the case was disposed of by the SC in January 2016 with a written order that noted that “the nurses working in private hospitals and nursing homes were not being treated fairly in the matter of their service conditions and pay” (Box IV.5). This was seen as a historic development by nursing organisations, on the matter of remuneration of nurses.

Box 4.5: Supreme Court order to the central government in 2016

The Supreme Court order directed the Central Government “to look into the grievances ventilated in this petition, by forming a committee within four months. After examining the factual situation, if the committee is of the view that the grievances ventilated in the petition are correct, the committee will make its recommendations, so as to do the needful for improvement of working conditions and pay of the nurses working in private hospitals and nursing homes within six months from its constitution, which can ultimately be given a form of legislation by the respondent-states or by the Central Government itself”.

In compliance with this SC Order, in February 2016, the MoHFW appointed the Jagdish Prasad Committee (JP Committee) to look into the grievances of nurses and provide recommendations to improve their situation with regard to their working conditions and remuneration. In September 2016, the JP Committee recommended increase in nurses' remuneration by establishing salary floors pegged to the remuneration in the state health facilities, but graded based on the size of hospitals and with an absolute floor wage of US\$ 270 (₹20 000). It also recommended parity in working conditions with the public sector with regard to leave, working hours, facilities, etc. (Section 1.2.6).

Box 4.6: Response of private hospitals to the JP Committee recommendations

In response to a request for opinion from the MoHFW in July 2017, the hospital members of the Association of Health care Providers of India (AHPI) argued that:

- While arriving at the recommendations, private hospitals were not consulted, and the recommendations of the Expert Committee did not incorporate their perspectives
- Nurses in the organized private Sector were, in fact, provided a much better and more conducive working environment and better working conditions, even in the absence of any statutory mandate
- Implementation of the recommendations would result in massive economic impact on private hospitals, which could render their very functioning unviable. The wage bills of nurses would stand inflated, at least two or three-fold, and other clinical cadres would also demand increasing their pay, as a logical cascading effect. This would result in long-term pricing implication on the health care system.

The JP Committee has also recommended that states should legislate in order to implement the recommendations of the committee. However, actions by governments at the state level also seem to have come under pressure from nurses' organisations, as was seen in Kerala²⁰. In the face of the lack of proactive steps by the government of Delhi, the Indian Professional Nurses Association filed a writ petition in 2017 in Delhi High Court (HC), seeking directions regarding compliance with above SC order of January 2016. Following an order from the Delhi HC in July 2017, the Delhi government also appointed a committee to look into the recommendations of the JP Committee and in June 2018 the Government of National Capital Territory of Delhi (GNCTD) issued an order to private hospitals to abide by the recommendations of the 2016 JP Committee. Strict action, including cancellation of registration of defaulter private hospital/nursing home, would be initiated in case of failure to comply with this order.

Box 4.7: AHPI challenge to the Delhi Government order

The private hospitals, through AHPI, filed a writ petition in Delhi HC in 2018, for quashing of this Order of the Delhi government. Claiming to be aggrieved by the order, as a representative of the majority of health care providers in the country, AHPI argued that:

AHPI was never intimated about the state committee;

- Directorate General of Health Services (DGHS) had effectively revised minimum wages of nurses laid down in Minimum Wages Act (MWA);
- DGHS has no jurisdiction in the matter -it is of MWA and Delhi Nursing Homes Registration Act (DNHRA);
- It was not financially viable as the implementation of the recommendations would result in massive economic impact on private hospitals and would result in long term pricing implication on the health care system;
- Public and private pay-scales cannot be equated, as it overlooks the fundamental differences between the two categories of nurses.

According to Girdhar J. Gyani, Director General AHPI, “The number of nurses employed in a private hospital is almost 3-5 times more than the government hospital for same number of beds. This means the budget of private hospital will rise in that proportion and which will not be sustainable. Average emoluments for B.Sc. Nursing in metro town like Delhi are one third of emoluments being paid in government service. Sudden hike of this magnitude is never heard for any

of the service. The raise in emoluments of nurse will open the Pandora box as other categories of health care workers will come up with similar demand" (Sharma 2019).

Officials from corporate hospitals claim that their business was suffering and a hike in nurses' salary will hit sustainability. "While operating expenses in a hospital keep increasing at normal rate driven by the inflation, there is no provision of hospitals increasing their rates for various medical procedures. There is growing perception that private health care providers were generating huge profits; on the contrary hospitals are finding difficult to survive," said Gyani.

Corporate hospitals have argued that the Supreme Court-appointed committee had said hike in salary be implemented through legislation, while in case of Delhi, it has been done through an administrative order.

<https://www.livemint.com/news/india/rs-20-000-minimum-wage-for-nurses-what-it-means-for-corporate-hospitals-1565673899224.html>

The Delhi HC pointed out that the SC made no reference to minimum wages, or to any exercise relatable to the Minimum Wages Act; and opined that "it would be doing complete disservice to the said order, as well as to the intent and purpose thereof, to seek to imprison it within the confines of the Minimum Wages Act. In fact, any such attempt would amount to rewriting the order of the Supreme Court. The terms of reference of the government appointed committee, too, refer to regulation of pay, and not to fixation of minimum wages. All submissions advanced by the AHPI and predicated on the Minimum Wages Act are completely misconceived" (See also Section 1.2.6). The Delhi HC rejected the challenges raised by AHPI and upheld the Delhi government Order of June 2018 to increase the wages of nurses in the private sector.

Having taken the SC order to the state level, and won a challenge by the hospital companies, AHPI, in the Delhi High Court, nurses' organizations kept the pressure on the state government to implement its own order. Nurses' unions such as UNA held relay hunger strike for over 40 days in November 2019. Thousands of nurses marched to the Delhi Secretariat on National Human Rights Day on 10 December 2019, and have met the chief minister several times. Yet the government has not taken any steps to implement its own orders to increase remuneration and establish parity between working conditions of nurses in private and public hospitals, leave alone initiating any action against the private hospitals or any steps to enact regulatory legislation. As pointed out by OB 2, "No (state government) has implemented (the SC order), except Kerala. In Kerala only after one lakh nurses marched to the state secretariat in Thiruvananthapuram and a state-wide strike, we could get it implemented".

4.3.3: Adherence to regulation

In their petition in the Delhi High Court, the private hospital owners pointed out that no reasons were forthcoming in the recommendations of the Expert Committee, for directing/permitting formulation of new legislation/guidelines when various related legislations, covering the field, were already in force. They said legislations such as Minimum Wages Act, Labour Act and Clinical Establishment (Registration and Regulation) Act, 2010 etc. already existed and applied to private hospitals and nursing homes. As mentioned in Box 4.5, the private hospitals contend that nurses in private hospital get a much better and more conducive working environment and better working conditions, even in the absence of any statutory mandate.

However, this study indicates there is rampant violation of the existing general and non-specific labour laws, in line with earlier findings and government reports.

As mentioned by a respondent, "None of the private hospitals implement it (the JP Committee recommendations) fully. The corporate hospitals, to avoid any major allegations, have devised an

²⁰<https://publicservices.international/resources/news/kerala-nurses-take-on-powerful-private-hospital-industry?id=8390&lang=en>

unwritten stipulation that ₹20 000 (US\$ 270) is the minimum and do not pay less than that. However, small hospitals and small clinics – 10-bed, 50-bed – still pay ₹13 000-15 000 (US\$ 176-203). A nurse in a good hospital may get up to ₹30 000 (US\$ 406) in the beginning, depending on allowances etc., but it does not match that of government nurses in similar position. But other facilities, such as rest, transport etc. are yet to come”, says OB1.

In addition, labour lawyers felt that the current legal framework and laws do not adequately cover the specific conditions of work of nurses, necessitating specific legislation, such as nurses deserving more than the minimum wage fixed for daily wage workers quoted earlier.

Advocate Ramapriya Gopalakrishnana expanded on this: “The existing legal framework does not adequately protect the labour rights of nurses. There is, therefore, a need to frame a separate sector specific legislation to protect the labour rights of nurses in India, particularly nurses in the private sector. This legislation has to be framed taking into consideration the principles contained in ILO convention number 149 and ILO recommendation 157”. She pointed out that Recommendation 157 provides for parity in remuneration and working conditions between the public and the private sector, which was diluted by the JP Committee when it recommended a graded salary level based on hospital size, pegged, but not equal, to the salary in public facilities: “I think if the duty and responsibilities of a nurse in a private hospital are the same as that of a nurse in a government hospital, then they should be paid on par. So, let's not go by 20-bed hospital or 50-bed or 100-bed”.

Nurses' organizations feel that they were now faced with a lack of political will. “The government has not been very active in improving working conditions of nurses in private hospitals”, as pointed out by several office bearers. “When we lobby and pursue the matter, they are not active, they are not rejecting or denying it, they try to show that they are implementing it, but actually legislation has to come, especially in the private sector,” says OB 1. Respondents say that it is the job of the government to enact the required legislation; in their opinion the delay is happening because of “issues of collusion and political-industrial nexus”. Said another officer bearer, “most of the hospitals have a good relationship with the government, the corporate hospitals – in this pandemic situation, hospitals have donated to the government funds. If they donate, who will go against them? Even the government will not go against them.” (OB4).

According to KI 1, “The hospital managements are actually very powerful, in every aspect. Legally they are so competent. All these hospitals are actually run by the MP, MLA those who are legislators, and in the executive also they are so influential. As far as the nurses in India are concerned this problem prevails only in the private sector not in government sector. Government sector nurses are highly qualified, highly paid – whether in Kerala or Delhi – they are very well paid and are getting all the benefits”.

Box 4.8 Earnings, operational costs and profits of hospitals

As mentioned in BOX 4.6, the AHPI claims that contrary to the view that private hospitals are making huge profits, in reality they find it difficult to survive. In view of the heterogeneity of the private sector this statement needs detailed examination.

An analysis of the revenues and costs of six major corporate hospitals in 2018-19 (Apollo Hospitals, Fortis Health care, Max Hospitals, Health care Global HCG, Narayana Hrudayalaya NH and Shalby Hospitals) showed that most of the hospitals spent 17-18% of their earnings on paying doctors, with Apollo spending nearly 28%; while **the average cost incurred on all non-doctor employees together, like nurses, administrative and janitorial staff formed just 20% of the earnings**. At the same time all the hospitals had increased their 'Other Expenses' by 10%, which included advertising and housekeeping costs (Soni 2019).

Table 4.1 Cost incurred by hospitals on clinicians and other staff members (₹ million)

Particulars	Sector average	Apollo	Fortis	Max+Trust	NH	HCG	Shalby
Clinicians	6 501	16 391	8 868	4 490	5 898	2 114	1 243
Personnel	5 408	9 143	7 113	7 460	6 241	1 845	646

The average revenue (earnings) of the six hospitals in 2018-19 was US\$ 369 million (₹27 282 million), while the average cost incurred by these hospitals was US\$ 328 million (₹24 219 million) - that was 88% of their revenue.

An earlier analysis for the period 2010-2014 of more than 80 private hospitals showed that their revenues and sales had increased over the years, so had profits. However, **the share of wages in total expenses remained nearly the same at around 17% and had not increased much**. At the same time, expenditure on outsourced jobs and advertisement and marketing expenses had an increasing share of expenditure (Chakravarthi et al 2017). A government audit report of 2017 pointed out that there was an expansion of the private health care expenditure by more than US\$ 473 crore and 528 crore (₹35 000 crore and ₹39 000 crore) during the two years 2012-13 and 2013-14 respectively. Despite this remarkable expansion, it was seen that the increase in tax base was not commensurate with growth in the private health care sector (Comptroller and Auditor General of India 2017).

Other studies have shown how charitable hospitals, considered as not-for-profit, misuse their trust status to claim income tax exemption but provide little or no charitable service, are managed as for-profit hospitals, and make large profits (Marathe and Chakravarthi 2019, Duggal 2012).

Such cursory examination of financial performance of private hospitals indicates that at least for big hospitals (whether for-profit or not-for-profit) earnings are not a limiting factor, as argued by the AHPI when it comes to paying salary to their employees. One doctor ,who runs a not-for-profit hospital, commenting on the lament of the corporate hospitals about their balance sheets, pointed out, “Clearly something makes it viable for them. If it was so unviable, then they should shut shop” (in Bhuyan 2020).

4.4: Accreditation and its impact

As discussed in Section 1.2.7, NABH accreditation is voluntary, yet hospitals are gradually opting for it as it is mandatory from the business point of view. As a senior nurse (KI 3) observed, accreditation is taken as a benchmark and an indicator of quality patient care, and hence private hospitals feel that it helps in attracting patients. Secondly, most government health insurance schemes as well as private health insurance companies stipulate NABH accreditation for enrollment. “You can work without NABH, but after a couple of months or years you have to be a part of this race as none of the hospitals make their own policy and protocols.”

“All of them hire a quality manager, which is decided by where the manager was working previously. The person recruited will bring the policy and protocol from that hospital, implement it here, and this hospital will also get NABH. Or the hospital hires a NABH consultant who gives them the policy and protocols. Even NABH does not audit patient care; they only come to audit papers. Patient interviews are selective and it is staged well. I was with NABH accreditation for more than 15 years, so I know these things; these accreditations are also very superficial” (KI 3).

According to industry representatives, “regulations are difficult to implement, but accreditation provides opportunities for quasi-regulation and self-regulation and should be aggressively promoted. The NABH accreditation system provides a quasi-regulatory framework for ensuring occupational health and safety in hospitals. For instance, NABH standards do cover reporting of accidents, training of nurses regarding hazardous chemicals in the hospital, use of fire extinguishers to douse fire, advanced levels of occupational safety in chemotherapy, dialogue with staff on whether they feel safe or not etc.”

While there is annual inspection and audit of accredited hospitals by NABH, N8 commented, “Every year NABH comes for audit. The hospital is informed of the date and time of this audit. So, on that day all the staff are called for duty, even those for whom it is an off day must come. The entire staff must be present and in this way the management shows that ratio is being maintained. During those three days of audit the prescribed nurse patient ratio is observed’. According to some respondents non-accredited hospitals have a lower nurse to patient ratio in comparison to accredited hospitals. However, incidences were reported by the respondents where NABH hospitals are also understaffed but they adopt different strategies during NABH audits such as; recruitment of staff on temporary basis, cancelling leave of nurses to maintain a certain number of staff on duty during audits or assigning double duty to nurses to increase the number of staff on duty.

“According to NABH, in the normal ward it must be 1:5 and in ICU 1:1. If the hospitals follow this, then revenue will be affected. What they do is 1:8 or 1:9 in ward and 1:3 in ICU” (N8).

When asked about whether the NABH team interacts separately with the nurses, the response of N8 was, “No, nobody will separately ask about problems; they only test about knowledge and education - about procedures and processes; they do not ask anything about working conditions, challenges faced at work”. The NABH audit/inspection team does not interact separately with the nurses and ask them about their working conditions or challenges faced by them. According to respondent N9, “They are seeing nurses salary slips and all. But it is not clear how they are getting satisfied during the time of the audit, we have a query about that, because personally, we know how much every nurse is getting. But maybe internally they are doing something, for the purpose of the audit”.

Another nurse N10, however, admitted that “there have been some improvements. For instance, NABH says there should be nursing station, nurses should have a comfortable room, there should be separate changing room for male and female nurses, there should be housekeeping staff. There are such rules and protocols of NABH, so there have been some positive changes in the working condition of nurses”.

As reported in literature on accreditation of hospitals, some of our nurse respondents pointed out that the documentation associated with such accreditation has increased the work of nurses. According to OB1, “Requirements under the NABH accreditation system have promoted proper documentation of the work done by nurses, and so checking or inspecting a nurse's work is easier. However, positive impact on their

working conditions were limited and the paperwork had increased the pressure and workload on nurses themselves”. According to N5, “With the NABH and JCI (Joint Commission International) accreditations the hospitals have to meet certain standards to be eligible for reissue of the certificate, as there is annual auditing. During the audits the nurses suffer a lot to complete all the pending requirements. So, the pressure and the burden on the nurses increases. But I feel that after the accreditation, the working conditions and regulation guidelines are better followed. Everything has improved, things are better than they used to be; institutions which are NABH or JCI accredited are better in terms of mainly infection or control and quality services than the other institutions which are not. But during the audit, their only aim is to meet the criteria, at other times they are little bit lenient. During that time (the audit/inspection) they just hurry to meet up all the requirements. That is a common practice”.

According to N9, “During the time of accreditation also they are not giving any kind of benefit to the staff. Only we face some kind of pressure. We have to do the audit and we have to ensure that the audit is a success. As I mentioned, different kinds of external audits, NABH, NACL, Green Audit, JCI, different kinds of external audits happen. But it will only be affecting the nurses' workload, not affecting the salary package”.

According to OB3, “This certification is for patient care. What is patient care? First there is the staff-patient ratio. This is not maintained by any private hospital. NABH does not even check all this. I have said many times that if one does not have the required staff-patient ratio, then the NABH certification should be cancelled. I have written mails - I will show you, with evidence I have shown that this hospital does not have the required staff-patient ratio. But the auditors will look at some instruments - some equipment that is available for patients they will look at and leave. Patient care is not just instruments, one requires people who can run these instruments too, is it not? So that ratio needs to be here too”. Representatives of IPNA wrote to the Quality Council of India over non-maintenance of nurse to patient ratios in NABH accredited hospitals and to conduct surprise inspections instead of pre-informed inspections, which would give the true picture regarding nurse patient ratio in the concerned private hospitals. The response of NABH was that it was not a regulatory body and it only prescribed standards and guidelines for certification after assessment.

India is a signatory of the ILO Convention 81 on Labour Inspection. However, neither voluntary regulation nor mandatory legislation are inspected in line with the principles of this Convention. The Convention specifies that labour inspectors do not need to give previous notice of their inspection, and that they should be able to speak with any employee in private. The study shows that there is evidence that inspections should be unannounced and cast a broader net of sources than those provided by hospital management.

In light of above observations of nurses regarding accreditation, which also match available literature cited earlier, and which have also been brought to the notice of concerned authorities by some associations, one fails to understand why NABH cannot cancel or refuse certification to the hospital for not maintaining the set benchmarks. Further, these findings of non-maintenance are contrary to the view of the industry that accreditation as self-regulation is easier to abide by than mandatory regulations.

Section 5

Experiences during COVID-19

As mentioned in Section 1.1, the year 2020 has been particularly challenging for health workers because of the coronavirus disease (COVID-19) that hit the globe, beginning December 2019. In January 2020, the COVID-19 outbreak was declared a public health emergency by the WHO, which called all countries to adopt a comprehensive approach in dealing with it and containing it through surveillance, detection, isolation and case management and contact tracing.

One of the strategies implemented by various countries, including India, to limit the spread of the virus was to impose a complete lockdown to achieve physical distancing and limit interactions among people. The lockdown shut down all public places, such as markets, educational institutions, factories, offices and all other workspaces, cancelling all public gatherings. Apart from being economically devastating, the lockdown, imposed at very short notice, increased hardships for the patients as well as health workers and health care facilities. The experience in Delhi, for instance, showed that a proportionately greater focus given to the COVID-19, resulted in grave sufferings to patients of other chronic diseases, such as cancer and tuberculosis, or those undergoing regular treatment such as dialysis.

As in most countries, in India too, the health systems were put to severe test and have been under considerable stress all through. While on hand the pandemic exposed the systemic weaknesses in the public health system, on the other it brought out the profiteering nature of the private sector. The largely unregulated private sector not only came under the scanner for charging exorbitant rates from patients for various procedures during a national health emergency, the poor condition of the health care workers in the private sector was also highlighted. In addition to severe shortages and poor quality of personal protective equipment (PPE) and risky conditions of work in hospitals, there was also a lack of proper quarantine facilities, long hours of work and lack of transportation. There has been a strong demand from health workers to treat COVID-19 as an occupational disease, so that the rights of health workers are protected.

Nurses in India particularly faced a variety of occupational health and safety issues especially in the early stages of the COVID-19 pandemic apart from increased exposure. Commonly experienced challenges at the health care facility comprised the lack of basic facilities like COVID-19 testing kits and appropriate PPE, comprising masks, face shields, goggles, gloves, gowns and overalls. An updated review by the International Council of Nurses (ICN) published in September 2020 indicated less than half the countries were reporting adequate availability of PPE.

In most countries, testing for symptomatic health care workers or nurses is not yet routine and this continues to be a problem because often it is too late by the time testing is finally done. Besides that, they also faced long working hours without timely salary payment, physical fatigue and psychological distress, lack of even unpaid sick leaves to recover well, lack of facilities for their quarantine or isolation in case they were COVID-19 positive. Further, nurses were made to re-join duty without confirmatory tests regarding their COVID-19 status, without even ensuring adequate safeguards to prevent intermingling with health staff from the non-COVID wards. In the public sector, nurses posted at local health centres had to handle all the community level work, such as performing the information education communication (IEC) work in the community.

Nurses also had to handle testing in the local dispensaries and referring COVID-positive patients to appropriate hospitals, despite shortage of basic protective equipment.

In July 2020, the National Human Rights Commission (NHRC) constituted an 11-member expert committee to assess the impact of COVID-19 pandemic on human rights. Some of those recommendations involved rights of nurses to get protection from viral exposure, to be able to get free, and quality health care for themselves and their families, especially if infected by corona virus. The committee also recommended humane working hours, consideration for the nurses' mental health, end to discrimination between contract workers and regular employees, timely payment of salary and allowances etc. Prior to this, in March the Ministry of Labour and Employment issued letters to private and public employers, saying that there may be incidents where employees/workers services may be dispensed with on this pretext or forced to go on leave without paying salary/wages. The letter advised the employers not to terminate their employees in this challenging situation, particularly casual and contractual employees or reduce their wages/salaries. It said that if any worker takes leave during this period, they should be “deemed to be on duty without any consequential deduction of wages”, and the same should apply to those working in an establishment that is ordered to shut down due to the pandemic²¹.

In effect, the COVID-19 pandemic added to or aggravated the pre-existing challenges faced by the nursing professionals. Respondents faced and/or got to know from colleagues and association members of loss of jobs, lack of PPE, non-payment of salary, increased workload, stress and harassment. Much of these problems are common to nurses in many other parts of the country (reference of some media reports).

5.1: Lack of transport, loss of jobs

Lack of transport and restrictions on movement during the lockdown affected not only footfall of patients in the hospitals, but also led to problems for nurses in reporting for duty on time. Several respondents mentioned that the fall in number of patients and thereby loss in revenue/ profit was used by many private hospitals to send nurses on forced unpaid leave and wrongful termination of nurses who could not report for duty. The managements did not provide transport facility to nurses for their daily commute, therefore, only those who could arrange private transportation managed to report for work, whereas a large section of nurses could not continue working during the lockdown. Nurses faced non-renewal of their contracts, loss of income and in many cases, loss of employment in the early stages of the COVID-19 pandemic. “Currently nurses in many institutions are reporting that they are being sent on forced leave or they are being dismissed citing inability to pay”, said N5.

According to N2, “They spoke to us as if we were family members, as if there were personal relations between us, such as: in our hospital (apne hospital mein) there are very few patients; how will we give salary? You people stay at home. We agreed. But after 2-3 days, when the hospital became a COVID hospital on 8 June 2020, we all got calls - I too got it- we all got one word from the in-charge that you all should join the hospital or resign. We asked about safety measures - where will we stay, what will our salary be? Will we get COVID allowance? They told us, 'You will not get anything. Either you do COVID duty or resign within 24 hours. When we went to the hospital, we were told that we would be called when required, we were not needed now. Later many staff got letters saying that “strict action will be taken against them as they did not come for duty and patients are suffering”.

We made phone calls, went in person and sent messages, saying 'we had come and met you yesterday for work. What is the meaning of sending such emails?' To this they said 'we have sent this to everyone.' This is the hospitals' clever ploy to harass nurses in these pandemic times. I have given a written letter and given them my email id. They have sent termination letter and legal action by post, saying that I did not come for duty”.

²¹https://labour.gov.in/sites/default/files/Central_Government_Update.pdf

Box 5.9: Impact of lack of transport during lockdown

N2 narrated the problems she faced in commuting to her hospital due to lack of transport

There was a complete lockdown. Still we kept going to work, sometime with a neighbour, sometime with some other staff, at that time few buses were running. I would leave house 3-4 hours early, the roads would be empty and I would stand there alone. In evening I would stand there at 5pm, but till 6-7pm I would not get any bus. I was afraid - bike riders passing by – seeing a girl standing alone. It was not just me, there are several staff who are female, all of them have faced similar problems. One day the bus services were completely shut and I was stranded on the road for an hour with no bus, Finally, I called my hospital, then the duty officer picked me up from there. After this incident I asked the management to either provide accommodation in the hospital or hostel or provide transportation. On the route where I live, there are many nursing staff, so I requested management to provide some transportation, It was just twice a day - morning and evening. They straight away refused, saying, 'no we will only provide in a 5-km range and you will not get any hospital facility'. However, the hospital administration finally cooperated when I requested that my roster be made along with my neighbour. Already a lot of our staff could not come for work due to lack of transport facility. Though the number of patients was limited, but the staff was also less. This arrangement also did not work for long. At that time, I said that please free us a little early, by 8-8:30pm so that I can return with the other staff, but they would let me go by 9:00 at night. If the other female staff has children, she will not wait for me till 9 if her shift gets over by 8pm. Why will she wait for me for another one and a half hour in her vehicle? She refused to wait saying 'look we cannot wait for you like this. You talk to your in-charge'.

N10 estimated that in his hospital about 20-25 staff had been sacked by the hospital on the ground that 'we do not need so much of staff at this time'. However, in one instance the termination was done in consultation with the concerned staff. Accordingly to N11, “The people who went on leave before the pandemic, couldn't come back because of the lockdown, so their services were terminated after a discussion with them. As the staff was sitting at home for three months, their mindset changed and did not wish to come back and thus, they were terminated. Other than that, nobody was fired and terminated, no salary was deducted”.

Some hospitals made arrangements for transport during the lockdown, such as that of N6, that provided ambulance and private cars for staff transportation.

5.2: Staff shortage, increased workload, lack of facilities

The challenges faced by nurses on duty were different. In the initial stages of the pandemic, private hospitals had closed down several departments. With many hospitals turning into COVID-19 facility or gradually resuming care services, there was increase in the number of patients, leading to increased workload on the already depleted nursing staff.

Respondents talked of extended work hours, low nurse-patient ratio, lack of rest period or breaks in between duty hours, and cancelation of leave including maternity leaves. According to some respondents, nurses continued working despite such conditions, due to humanitarian aspect of the pandemic, fear of losing their job, loss of income, and lack of good employment opportunities.. N5 felt “There is no proper system in place and currently in COVID scenario after 6-7 hours or even 12 hours in PPE, the nurses are not relieved on time”. According to N3 they were being called in the middle of the night to come for duty; before COVID this did not happen but after COVID it is very common now. They could get called even on their off day; the hospital could call them any time to come to duty due to staff shortage. Further, “In non-COVID area, we are having 12 hours night (8pm to 8am), but in COVID area we had 6-hour night shifts. So in COVID area we need more staff as compared to non-COVID area. Due to shortage of staff the work load

is too much and it's exhausting. Since it's a crisis time, there is staff shortage and we get no extra help and have to manage everything ourselves in our department. The hospital is now divided into COVID and non-COVID areas – this has created shortage of staff and increased our work pressure. Though the hospital is recruiting new staff but they need to undergo some training before they can start work. Except for eating and doing my daily activity I am unable to do anything else as I am exhausted by the time my shift ends. Whether in ICU or in general ward, in all the departments we have GDAs (General Duty Assistants), both male and female. But now they have reduced these GDAs so without them it is hectic.”

In some hospitals the nurses working in the COVID areas did not receive even basic facilities such as refreshments, separate drinking water facility or cafeterias, dedicated donning and doffing areas and appropriate accommodation facility, thereby exposing nurses working in the non-COVID areas to risk of contracting infection. During the FGD, nurses explained, “in our COVID ward there is no drinking water facility for nurses. Accommodation has been given on the third floor ward of the hospital, where 40-50 staff has to use two toilets only, no proper food is being provided, about 8-10 staff stay in one room. COVID positive patients too are staying in the same ward, exposing the nurses to risk of infection. So, there is no safety for the staff”.

There were some exceptions though, and we were told of a hospital where the nurses did not have to face such problems.

According to N7, “The recent MD of XX hospital is very good and understanding and the management has done a lot for nurses in his hospital. They arranged a floor for treatment of all nurses who tested positive, free COVID tests were conducted and there was quarantine and treatment facility for nurses who turned positive and paid leave. But other hospitals did not follow the safety protocols adopted by the XX hospital. The nurses were provided food, refreshments and whatever they needed. Regarding PPE, initially there was lockdown, so there was no supply. Besides, no one knew anything about this disease. When the factory was closed, we had some problem with supply of the PPE kits, but as soon as the factory work resumed, there has not been any problem and hospital provides everything.

5.3: Impact on salary, other financial entitlements

While nurses reported working for more than the stipulated duty hours, not all received additional pay or overtime for these extended work hours. Not all respondents reported provision of COVID risk allowance by the hospitals. This was especially highlighted by nurses working in COVID areas. During the FGD, nurses reported, “No COVID allowances. Initially, they came out with a letter that they will give per day ₹500 to doctors and ₹300 (US\$ 6 and 4) to staff. However, after two months they denied having any COVID allowance”.

In some hospitals, salary was withheld for those nursing staff who were unable to report for their duty during lockdown. “During the lockdown - some people could not report for duty due to lack of transportation etc. Though initially, the hospital said everybody would get salary, eventually, only those who were working continuously got salary. Those who could not come for duty did not get salary” (FGD). When a nurse (N2) went to the hospital and said she wanted to work, she was told 'Child, don't come now, not many patients are coming, patient inflow is less, how shall we give salary? Don't come now, stay at home. there is no work, what will you do here’’. But thereafter, salaries were not paid to such nurses.

Respondents either faced or reported reduction in salary, increment or no bonus from employers on account of lower footfall, loss in business and increased expenditure. N8 told us, “In many hospitals staff were forcefully made to take leave without pay - salary was not given. In one hospital in Gurgaon, staff nurses were asked to go on leave for almost 3-4 months. They were not sacked, but the salary was also not paid. About 50 nurses faced this problem - no salary, made to sit at home, not allowed to come for duty. In some hospitals there were deductions in salary - 10%, 15%. Not in corporate, but non-corporate, medium-level hospitals ...”

According to N6, an in-charge in a corporate hospital, “Yes, salary is regular, yearly appraisal and

increments are also there. But since COVID-19, the condition is deteriorating and the number of non-COVID patients is getting low. So, no increment this year and based on salary scale, up to 50% salary is being cut. Mine is 15%”.

She also said, “We are not getting any medical allowance (other than insurance,) because we are told occupancy is really low, OPD closed, so organization is running out of money”. N2 described her experience with the management when the nurses collectively approached the management for COVID allowance, “There was a lot of bargaining with us - it was as if we were purchasing vegetables. We said, 'Sir you think about it - with our salary of ₹15 000 (US\$ 203) we will get our family tested, have nutritious food, pay our rent - what all can we do with ₹15 000? At least give us COVID emergency allowance. Consider it as high-risk allowance and give it'. After initially offering just ₹5000 (US\$ 67) they increased the figure gradually, and eventually announced an allowance of ₹10 000 (US\$ 135). But till now, we have not received any allowance,” said N3. “Our annual year is from April to March, so we used to get annual incentive in April, but since the beginning of this pandemic, we haven't got any incentive or extra amount. I am not saying that they deducted our salary, but didn't give any extra compensation either in this pandemic. We asked them (management) to give us some kind of compensation, since we are risking our lives and working in COVID areas, plus even in non-COVID areas, there are some asymptomatic corona positive cases. But the management denied us compensation saying, 'We do not have extra earnings so we cannot give you compensation'. That's it. Now they are giving us money for the extra shifts and extra working hours”. According to N7, “There were not enough patients in private hospitals, so they started sending nurses on leave. Yes, unpaid leave”. According to N6, “We are not getting any medical allowance (other than insurance) as occupancy was really low, OPD is closed so organization is running out of money”.

Interestingly, while some hospitals may be reducing remuneration or other financial entitlements during the pandemic, one respondent (N8) mentioned that to cope with the staff shortage, to attract nurses, his hospital had increased the starting salary. “During the COVID pandemic many staff could not come due to transportation problems or left due to fear. So, there was shortage of staff. To attract staff, the hospital increased the starting salary.

Before the pandemic, it was below ₹22 000 (US\$ 298) and has been increased to ₹25 500 (US\$ 345) due to shortage of nurses during the pandemic”. According to N11, “I don't think employees were terminated, salary in my institution was not deducted, in fact they made extra payment to staff who looked after the COVID patient.

So there was COVID allowance in their salary”. Similarly, N1 also reported that, their hospital gave extra benefits and did not reduce anything. Those who are looking after COVID positive patients were given incentives on daily basis – medical insurance is also there. The hospital has also given assurance that in case any staff gets infected with COVID, hospital will provide treatment. That is given in writing. Then the incentive is that those who are looking after COVID positive patients they will get extra salary for one day - if you are doing six hours' duty you will be paid for 12 hours. If you are going for 15 days then you will be paid for 30 days - double the salary.

Now the trend has changed. Now they are cutting the extra payment by 50% - if you are doing 15 days' duty you will get extra payment for 7 days - It is halved now. If you are doing duty for 10 days then you will get payment for 10+5 days only”.

5.4: Occupational health and safety

Occupational health and safety (OHS) at work place was most hit during the early stage of the pandemic. Respondents reported lack of appropriate PPE, shortage and rationing of PPE kits and discrimination in distribution of PPE among doctors and nurses and even among nursing professionals working in the COVID and non-COVID areas. Then there were problems associated with prolonged wearing of PPE. As N8 observed, “During COVID-19, all private hospitals in Delhi faced the issue of availability of good

quality PPE in large numbers. In April-May the conditions were appalling, with no masks and poor quality of PPE. Because of such conditions, many nurses got infected. Only since June-July proper facilities, proper PPE, started to be provided to nurses taking care of COVID patients. Almost 70 nurses from my hospital got COVID-19. The first two months were most dangerous – 50% of the staff was getting positive, because of lack of PPE. The situation is better now, all nurses in COVID ward are getting complete PPE kit and in non-COVID wards also masks and gloves are being provided”. In the hospital where N2 worked, nurses were given cloth masks which they had to wash daily and carry to work; they were not given surgical use-and-throw masks. She said,, “In fact we were buying our own masks and wearing them. For one mask I was told that I should give in writing or pay for it; this when I was doing hospital duty, taking care of patients, and could pick up corona virus infection from the hospital. I have given a written letter for one mask”. According to N10, “I am a nurse in emergency, where there are no separate tests. We do not know which patient has what infection. Like if a COVID patient comes in emergency and does not have test report, we cannot confirm if the patient is positive or negative. So, we face a lot of risk in our workplace”.

According to N5, “Different cadres of employees are differentiated while distributing PPE - like a particular cadre of employee in a hospital was given full PPE one month before the nurses, and when somebody went to ask why we were not getting PPE, the management said nurses are large in number, so we are not eligible for PPE and what we are getting is adequate. So there was no central distribution unit for PPEs”.

In addition, “the quality of PPE is questionable. Due to the PPE kits, nurses are also facing many problems like skin allergies, breakouts, nasal bone scars, cuts, brittles, discoloured nails, or dry throat, because of not being able to drink water for more than six hours or use the toilet. So the health of many of the nurses is suffering. And infected PPE is also not discarded properly”.

In several hospitals, nursing staff had to write collectively to the management and/or resort to some form of protest to get the management to provide appropriate PPE and other facilities, which were met with limited or very little success and even victimization, as described by N2 and also during the FGD (See also later in this Section). The hospitals started giving PPE and masks only when the nurses refused to work without adequate protective equipment. “We fought for the PPEs, we said we want the entire kit and only then we will go near the patients. If it was not available to even one staff, we will not go near the patient even if it is time for the patient's medicine.” (N4).

In the initial stage, of the epidemic the nurses did not have adequate training on the standard operating procedures (SOP), guidelines/ protocols or infection prevention and control (IPC) guidelines from their employers. In later phase, while nurses working in COVID dedicated areas were trained on the SOP and protocols, those working in non-COVID areas had to search and refer to the videos/training materials on the MoHFW website to equip themselves for their day-to-day work.

To manage rationing and limited supply of PPE, the nurses had to adopt measures such as cutting down consumption of water, having meals at the end of the shift, not using the toilet in between duty shifts even during menstruation, or not taking breaks in between shifts fearing that the PPE kit once contaminated will not be replaced by the management. While the supply of PPE kits improved after some time, quality of protective equipment provided for nurses working with COVID patients remained an area of concern, as continuous usage of poor quality of PPE kit for 8-12 hours resulted in profuse sweating, cuts, rash and skin irritation among nurses.

The experience with medical care and medical insurance pertaining to COVID-19 such as: precautionary measures, test and treatment for COVID infection differed across private hospitals. While respondents from corporate hospitals reported receiving free testing and medical care for COVID infection, and quarantine/isolation facility; there were reports from non-corporate hospitals that nurses working in the COVID areas were not tested for COVID even on developing symptoms. They were also not provided appropriate quarantine facility, and were called back on duty before the mandatory 14 days quarantine period.

“In this pandemic if any staff tests positive for COVID, our hospital does not charge them anything. The treatment is free cost.”- Nurse Respondent from a corporate hospital

“Two of my room mates - nurses - had symptoms - fever and sore throat. They went to the doctor and were told to get RT-PCR test. They struggled with the management to get the test done for ten days. Their symptoms went away in that time, but their test was not done. The delay was because the hospital was asking them to pay the full amount for the test, which at that time came to ₹5000 (US\$ 67.6), while the management was saying that everything was free for staff. Now the cost of the test has come down to ₹2400 (US\$ 32). The staff wanted the test cost to be reduced for them, but these people (management) kept on delaying ... their symptoms went away, but the test was not done”- (FGD)

Some respondents even reported that convincing management that the infection was contracted on duty is a major challenge. In most cases the management deny any medical support on the pretext that the health personnel might have contracted infection due to negligence and error rather than due to the nature of their work or lack of adequate safety measures (N5).

5.5: Mass resignations

Confronted with all such problems and pressures, nurses had resigned in large numbers, said some respondents. According to N5, “Many have resigned, mainly because of family pressure. I don't think anyone is keeping track of how many are resigning and leaving. Because in the institution I was working I think almost 150-200 people resigned in that time. Either because they want to be with their families, or because they were not able to take care of their health. They could be at risk of contracting covid: maybe they were sharing accommodation with other nurses who may have been working in COVID areas or who may have turned positive. It could also be the sudden increase in workload leading to a decline in their physical and mental well-being. So they prefer to spend some time with their families. After some time they may return to Delhi. It is interesting to note that it is only nurses who are resigning. The COVID pandemic has brought to light the issues that was pre-existing. In fact, the issues have got further aggravated. That is the point I am trying to put across. It is nurses who are resigning and I have not seen many such resignations from other fields”.

“One or two pharmacists may have resigned, but I don't think any other professional or any other person who is in the non-medical sector or even in the clerical job has resigned. And other health care staff are not feeling that much pressure compared to what we are feeling,” N5 added.

5.6: Professional hierarchies and discrimination

The doctor-nurse hierarchy played out to the advantage of doctors during the pandemic in several ways:

In work distribution – According to a critical care nurse, N1, despite often possessing skill and training, nurses are not permitted to perform certain clinical procedures, such as intubation and doctors maintain strict professional boundaries of responsibility and autonomy at work. He mentioned that during the COVID-19 pandemic, critical care nurses have been asked to perform certain procedures that were previously reserved for doctors only.

In distribution of scarce resources – Given the professional hierarchies, where doctors are valued more than nurses, another disadvantage was that distribution of resources would be guided by doctor-nurse hierarchy, as shared by one respondent (N1). “There is only one ventilator. Between a 40-year-old doctor and 40-year-old nurse, it is the doctor who will get it. These things happen. They are happening in other states and countries. Will happen in India also,” he said.

Differential access to treatment - the difference in salary between doctors and nurses shapes access to and affordability of COVID care in case of contracting infection in hospital setting.

“One of our doctors got infected, became critical and was admitted in AIIMS. If a nurse was in the same situation, it would be difficult. The doctor had enough money so that's why they could arrange a bed in a

private hospital when his condition deteriorated further. But in the same scenario even a nurse with 20 years of experience cannot afford this, forget about a fresher,” said N1.

Resignation of nurses, collective action by nurses – One respondent (N5) pointed out that nurses were the ones resigning in large numbers, not doctors or other workers in the hospital.

Or for that matter, others persons in the non-medical sector as well. It was the nurses who were most exposed and most at risk; who bore the brunt of providing the medical care to COVID positive patients, whereas doctors would visit and leave. Hence, nurses were the ones who were either quitting their jobs or took recourse to some collective actions for redressal, such as approaching the court in case of their dismissal, or for getting PPE.

5.7: Support provided by nursing associations/unions

Nursing associations purchased and supplied masks and PPE in the initial phase of the pandemic to hospitals across the country to be provided to nurses. They also helped by organizing transport and quarantine facilities, taking up nurses' problems with hospital management, organizing training for nurses on use of PPE and infection control procedures and organizing psychological and financial support. Unions filed petitions in the Supreme Court and Delhi High court seeking directives to governments to address the lack of PPE and ensure decent working conditions for nurses and all health care workers in all hospitals.

In some instances, unions also extended support to nurses who faced harassment and whose contracts were not renewed as they took collective action and wrote to the management regarding lack of PPE and other facilities. One organisation of nurses also organised transportation for nurses stranded in the GCC countries back to India, as shared by OB2: “(Organisation X) could charter a flight from Saudi Arabia, to bring 177 nurses [back] to India. More than 50 nurses were pregnant and 11 had newborn children. There are four more flights [that] we are planning”.

At the FGD, nurses described in detail the ways in which their collective efforts were broken up in several ways by the management, simply because they raised the issue of lack of OSH during the pandemic. These nurses had to approach the Delhi High Court as their contracts were not renewed and they were being asked to give guarantees that they would not demand PPE, stage protests, or inform the media, if they wished to be re-employed.

Nurse respondents also mentioned that they were aware of their roles and responsibilities and that they received support in this from nurses' organisations. According to N2, “We shared our problems with them [nurses' organisation representative] and they suggested the way to go about it properly and in a peaceful manner. Because in this situation of social crisis, we have to get together and fight. Our fight is not just with private hospitals, we have to fight against this disease”.

BOX 5.10 Normalizing the pandemic - Rolling back of good practices

While some hospitals were providing allowances, adequate PPE, etc., and some were not, what seems to be happening is not the spread of the good practices but rolling back of good practices by those who were providing them.

Some corporate hospitals gave PPE, extra allowances, provided transport, quarantine and accommodation, leave. However, given the cases on rise, hospitals have retracted many facilities that were being provided to nurses, medical care is one of those. One respondent expressed apprehensions regarding occupational safety if COVID is accepted as a common disease. “Hospitals will cover but then COVID is becoming common, will start getting treated as a regular disease”. Gradually the hospitals have decided to take up COVID as any other disease. The nurses are no more provided with any additional facility that they were receiving in the month of February to May, such

as doubling of salary, mandatory quarantine for 14 days, free medical treatment, regular testing. In one case, the hospital stopped providing the allowances and other facilities as “other hospitals” were not providing. In another case, they were being rolled back as the pandemic is being accepted as something to live with now. Concerns are arising among nurses about accepting COVID as normal and hence under the same working conditions how will nurses cope if they are infected? How will they bear the cost of treatment? What happens when family members get infected? When things return to normal, we will not have insurance cover, etc. Who will pay?

Section 6

Conclusion and Recommendations

Nurses in private hospitals have been raising issues related to their status and working conditions for more than a decade, through petitions to the government, the courts and the Parliament. However, since most of these processes have been led by their associations in rapid response to specific circumstances and events, rigorous documentation and analysis of these issues has been deficient. This qualitative study attempts to give voice to nurses working in private hospitals in Delhi, as well as places the evidence derived thereby in the larger context of the health care sector in India.

One of the main findings of the study is that of the overarching failure of the private health care sector to respectfully acknowledge the nursing cadre as comprising health care professionals with a high level of training and potential experience. Their low levels of remuneration, which the study finds, varies from less than US\$ 203 (₹15 000) for freshers to not more than US\$ 609 (₹45 000) after over 10 years of experience, is an important factual measure of their exploitation. Very few nurses rise in the ranks of hospital management to wield any participation and influence upon decision making for both, patients and nurses. While those few who get into supervisory or management positions achieve a fair level of remuneration well above US\$ 676.6 (₹50 000), the gap between them and a majority of the nurses in terms of remuneration as well as power remains extremely high. In fact, the nurses face high levels of job insecurity, as the current practice prevents upward mobility, by replacing experienced senior nurses with freshers at lower salaries to protect the status quo of the existing hierarchy and to prevent escalations in running costs. Alongside this state of inadequate salary levels, the study finds disturbing evidence of insulting behavior, public humiliation and harassment in various forms, which are also ways of subjugating the nurses. The study also points to poor nurse to patient ratios, at times being as low as 1:30. Such poor staffing in order to cut costs point to the compromises made by private hospitals in providing quality nursing care to patients.

The lack of formal employment benefits is accompanied by continuous attempts to dilute even the hard-won concessions that exist by processes such as short-term contract. One of the most extreme findings of this study (though it affects fewer nurses now) is the practice of retaining them as 'bonded labour' for fixed periods of time through various means such as retaining their certificates and asking nurses to pay to get them back if they wish to leave (a practice now banned by the INC); or keeping post-dated cheques made out by them to the management for large sums as guarantee against leaving.

These practices contrast sharply with the working conditions commanded by doctors and management themselves, with the assumption that it is only the doctors that bring 'money to the table'; one that disrespects the enormous contribution of the nursing cadre to patient care and well-being. Furthermore, lack of basic facilities at their workplaces makes them vulnerable to occupational hazards and the insecure working conditions have adverse impact on their mental health. Several nurses have said that there is discrimination against females as well as male nurses and denial of basic rights such as the right to form associations. The low salary and poor working conditions and low social status and dignity were seen as contributing to the nurses' migration out of the country.

It has also emerged that improvement of conditions and more opportunities in the public sector would prevent nurses from leaving the country. Lastly, grievance redressal mechanisms are either non-existent or not properly observed.

All these issues of low salary, insecure jobs, lack of attention to working conditions and occupational safety of nurses, and the contingent quality of care for patients have been highly exacerbated during the pandemic. The study clearly documents the extreme challenges faced by nurses; whether it be in organizing transport during the lockdown, working without adequate PPEs and training, struggling through impossibly long hours without rest, food, water or even toilet breaks. While one expects all health care personnel to put in extra effort in times like these, what emerges is the lack of support, care and appreciation that one would otherwise expect from the management. Instead, leave, quarantine facilities and due extra remuneration were all found to be compromised, leaving nurses to essentially fend for themselves and show up for work or be penalized, regardless of the circumstances.

It would be expected that regulatory mechanisms that have been set up to ensure quality of care would take care of at least those issues related to the working condition of nurses that pertain directly to patient care. However, the study throws light upon how observance of voluntary norms under accreditation schemes such as NABH are subverted or circumvented by the management, presumably with the connivance of the regulatory authorities; prescribed standards and conditions are observed only during the inspection for accreditation and diluted once it is over. This is made easier by the fact that inspections are announced in advance which gives an opportunity for the hospital management to prepare the hospital for the visit and providing a false impression of adherence. India is a signatory of the ILO Convention 81 on Labour Inspection. The Convention specifies that labour inspectors do not need to give previous notice of their inspection, and that they should be able to speak with any employee in private.

The study shows that neither voluntary regulation nor mandatory legislation are inspected in line with the principles of this convention; that there is evidence that inspections should be unannounced and cast a broader net of sources than those provided by hospital management.

The study also points to the reluctance and resistance among private hospitals to abide by court and government orders to improve the salary and working conditions of nurses, and finally to the lack of political will to enforce these orders that would give relief to the nurses and provide them with better conditions of work.

The case study shows how collectivisation, through industrial action, public campaigns, and legal action, was central to bringing a landmark judgement by the SC with regard to wages and working conditions of nurses. It was only the continuous and persistent efforts of nurses themselves, through their associations and unions, that led to legal steps to change their situation, such as the petition in the SC and the subsequent judgement to legislate labour rights of nurses, to the government recommendation and order on parity among the private sector and public sector nurses. The right to associate and form unions is, therefore, particularly important in the current scenario, to not only take up issues around the rights of nurses as skilled health care professionals, but to also extend support to the endeavours by the government and private hospitals for improvements in the overall health system on behalf of patients. However, private hospitals do not want to have a union in the hospital as they perceive it as a threat and as a disruptive practice when nurses demand their rights.

Formation of unions is actively discouraged by the management, as evidenced by the reluctance to hire male nurses who are seen as being more active in pointing out and raising problems at work as well as in forming unions among nurses, and victimization of those who attempt to create awareness and organize nurses for their rights. While there is a perception that workers' organisations tend to focus on and limit themselves to their own interests, to issues that affect only them, many of the issues raised by nurses' organisations also have a direct impact on patient welfare and public interest. They also include demands for respecting infection control protocols, including PPE quality, quarantine and safe accommodation, improved nurse to patient ratios. Respondents stated that they were very aware of their role and responsibilities, especially during the social crisis arising from the pandemic; they were aware that they needed to work along with others to fight the pandemic; their fight was not just with the private hospitals. In this they had the support of their nurses' organisations.

The study also brings out the contribution of upstream factors such as the nature of nursing education to the issues being faced by nurses in realizing their rights as employees.

The lack of quality of nursing education puts working in a 'good hospital' to gain experience at such a premium that many nurses compromise on remuneration in exchange. The study also demonstrates the nexus between nursing education and the employment of nurses in the private sector, whereby private hospitals are running their own nurse training institutions, leading to the hiring of fresh recruits at conditions that are less than par. The nature of nursing education was also cited by many (especially female) respondents, as a reason for their failure to stand up for their rights, since there is a heavy stress on being dutiful and obedient.

In summary, the existing environment of a poor regulatory mechanism, in combination with the imperative to maximize profits by keeping HR costs down in a sector that is otherwise HR-intense, is enabling a widespread neglect of the nursing cadre in the private sector in the capital city of Delhi. It is pertinent to point out that the larger - especially corporate – hospitals seem to show greater adherence to laws, policies and regulations, than the smaller hospitals. Possibly, it is their relatively greater financial stability that allows them to do so. However, they too do not match the employment conditions prescribed for the public sector in terms of remuneration, career stability and growth and social security. The study reveals that they get by with the minimum required to satisfy the letter of the law or the rule, rather than with any concerns for parity within their own hierarchical structures. In a world where nurse practitioners are considered as logical replacements for doctors within a limited and defined level of medical practice, relegating nurses, especially at the beginning of their careers, to a status slightly better than ward attendants seems to be an expedient incongruity.

- The year 2020 was declared as the International Year of Nurses and the year 2021 has been declared by WHO as International Year of Health and Care Workers. It is hoped that the study contributes to firm action in the coming year to ensure long overdue reforms and regulations to improve the employment and working conditions of nurses, in the firm belief that it is essential, also, for the well-being of patients as well as the sector as a whole. It is important to recognize nursing as a pivotal component of the health care system. Some specific recommendations that emerge from the study as well as the online consultation on occupational safety and health are as follows:
- Centre and the state governments must strictly implement the JP Committee recommendations and initiate steps towards enacting legislation to specifically regulate salary and other working conditions of nurses. In doing so, policymakers need to subscribe to the recommendations laid down in the Decent Work theme of ILO, upheld by WHO for health care workers, the ILO Nursing Convention 149 and ILO Convention Number 155 – the Occupational Safety and Health Convention. A statutory oversight mechanism needs to be set up to ensure and monitor compliance on a regular basis. Accreditation should not be treated as a substitute for these statutory mechanisms.
- Recognizing the fact that a high percentage of health care requirements are currently being taken care of by the private sector, the government needs to explicitly acknowledge its regulatory role in ensuring that existing quality control frameworks, entitlements, schemes and laws apply upon the private sector.
- The fundamental rights of freedom of association and collective bargaining need to be respected and avenues for social dialogue kept open. Unionization of health workers must be permitted as a matter of right and any discouragement needs to be curtailed proactively by the supervisory mechanism set up as above. Unionized nurses have enough power and visibility compared to individual nurses to not only raise specific workplace issues but to also bargain for long-term changes in public policy that directly affects them. A unionized health workforce not only leads to a higher patient safety, better conditions for workers in health care facilities, but also to a robust public health system. There is ample evidence internationally that higher levels of union density led to better outcomes for both workers and patients.
- Nurses must be directly represented, respectfully heard and formally made part of the decision-making process at the level of the workplace and the broader public health policy making. Separate nursing directorate, nursing universities and genuinely autonomous state nursing councils must be established

in each state to facilitate authentic representation of nurses.

- Nurse staffing norms in India must be immediately revised in the light of international norms and research evidence available on actual workloads of nurses, optimal nursing requirements for patient outcomes and quality of care. Nurse-patient ratios must be included in the oversight mechanisms enacted and strictly adhered to in health care facilities.
- Considering that nurses are a permanent requirement for the running of any hospital, contract employment of the nursing cadre needs to be stopped; they must be included in the formal HR structure of the employing institutions.
- Reforms and adequate effective supervision mechanism needs to be urgently instituted in nursing education to address the poor quality of education. Course content needs to be reformed to ensure that is not only technical, but also empowers nurses with respect to public health issues as well as their own rights alongside duties.
- The relationship between nursing education institutions and private hospitals needs to be rationalized to ensure that there is no automatic employment benefit to employers beyond the formal period of internship.
- Although the Epidemic Diseases (Amendment) Bill 2020 has been recently passed by the government to protect health care workers, including nurses, from being subjected to violence, it does not address their other occupational safety and health-related needs and demands.
- Capacity building of institutional heads, administrators, and managers of various health care institutions to reduce occupational hazards and improve safety standards within health care facilities need to be instituted and specifically monitored as part of the regulatory framework.
- Dedicated occupational health care nurses should be appointed in the hospital for the support of other colleagues as well as of the patient for a healthy work environment.
- Although the National Policy on Safety, Health and Environment at Work Place 2009 and the Employees Compensation Act, 1923 (Schedule III, Part A) can be technically utilized by health care workers to demand their occupational safety and health related rights, it is high time that the Government of India explicitly declared COVID-19 as an occupational disease. In this regard, the recommendations of the NHRC Expert Committee relating to health care workers should be also be widely disseminated and implemented by the concerned state authorities.

The study reinforces the overall understanding that there is an inherent contradiction between profit-making in health care and enabling decent employment and working conditions for nurses. Conversely, it also suggests that goals of health care systems as well as concerns of health care workers are better addressed through formally institutionalized, publicly financed, and publicly delivered systems. The study team recommends that the government develop an explicit road map for expanding and strengthening public health care services. Finally, civil society needs to prioritize advocacy on nurses' issues, especially for the enactment by states of comprehensive legislation as recommended by the JP Committee, to improve and regulate the employment and working conditions of nurses in private sector, including their occupational safety and health.

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This exploratory study documents the employment and working conditions in selected private hospitals in Delhi as well as relevant government provisions and legislation to improve, safeguard and regulate the work environment.
