**Who Cares For The Nurses?**

On reading news reports about attacks on nurses and doctors during the current pandemic, my thoughts flashed back to this particular nurse X from the civic hospital I had a chance opportunity to interview for my study. While describing the working conditions in the public hospital, she pointed out how heavy pressure of patients often necessitated floor beds and in turn led to arguments with patients and risk of violence. Narrating an incident, she told me how a male patient in the ward had suddenly attacked her with a surgical scissor from behind, without any provocation. Had it not been for the presence of the ward boy, who overpowered the patient in the nick of time, the attack could have been fatal. She further disclosed that she was asked to go on leave for a few days. Though shaken, she resumed work within a week’s time; no action was taken and work went on as if nothing had happened.

In the research study I had undertaken in 2010 to explore their socio-economic conditions in Mumbai, majority of the nurse respondents across healthcare institutions in the selected wards mentioned ‘recovery of critical patients’, ‘helping to reduce the suffering of patients’, ‘saving lives’ as situations that gave them immense satisfaction. Recounting an incident, a nurse pointed out that she was deeply touched when a critical patient on recovery remarked that she was like God to him. ‘Money is not everything’, she added, ‘the blessings of our patients keep us going, despite all difficulties’. Encouragement and appreciation by doctors and administrators added to the feel-good factor about their work, besides gratitude from family members and friends for their guidance in times of ill-health.

At the same time, the nurses highlighted several issues which prevented them from putting in their best efforts. Without exception, the biggest obstacle they faced was an acute shortage of staff, not only of nurses, but also Class IV employees, particularly in civic hospitals. Many posts remained vacant in these hospitals partly due to non-availability of qualified nurses from the reserved category but mainly due to inadequate funding for the public healthcare system. The private healthcare institutions had their unique reasons for this shortage: A high attrition rate especially among nurses from Kerala who quit on getting jobs abroad paralyzed the smooth functioning of the hospital, increasing the work pressure on the remaining staff. Private nursing home owners cited ‘better salaries offered by others’ as responsible for staff shortage. Indiscipline and absenteeism of ward boys, excessive interference of local Corporators in admissions and lack of security especially in civic hospitals often resulting in scuffles and assaults on nurses and doctors were other critical issues highlighted by the nurses. In private nursing homes, inflated bills saw nurses bearing the brunt of the aggrieved public.

In terms of their work, nurses expressed unhappiness that there were hardly any opportunities for career progression; little respect and dignity of labour and that in spite of putting in many years of service, they had little scope for autonomous decision-making and had to carry out the doctor’s orders. Besides, given the occupational hazard of contracting infections, nurses did not have access to free medical treatment uniformly across public hospitals, in spite of working in the health sector. The work of the nurses could be summarized as ‘understaffed, overworked and underpaid’. A comparison of salaries paid to nurses in public hospitals in Mumbai vis-à-vis those of nurses in other countries brings out the gaping differential in their emoluments. The average starting salary paid to nurses in Indian public hospitals is INR 40,000 as compared to nurses in US (and Australia) who earn around INR 3.5 lakh to 4 lakh per month, working at least 5 days a week; besides, night shift, overtime and posting in specialty wards command additional remuneration. In New Zealand, the average salary paid is INR 2 - 2.5 lakh whereas in London it ranges between INR 1.8 lac to 3 lacs depending on experience. A government job in Middle East like UAE, Qatar pays a minimum of INR 2 lakhs per month; in Kuwait, salary starts at INR 1.5 lakh per month. The Memorandum to The Seventh Central Pay Commission on behalf of The Nurses of India, published by Trained Nurses Association of India (TNAI) in July 2014 pointed out that the salary of a senior resident doctor was equal to the scale of the Nursing Superintendent which is the fourth level promotion of a staff nurse if at all she reaches that stage. While nurses are underrated as compared to doctors worldwide, the discrepancy is starker in the Indian situation, where doctors are paid almost four to six times that of nurses, while in other countries the salaries of doctors do not exceed more than double the salary of nurses.

Fast forward to 2020. Not much has changed in the interim period. In fact, working conditions have deteriorated and the Covid-19 pandemic has overwhelmed the health workers with unprecedented hardships. In addition to the shortage of health workers, the pandemic has also witnessed shortage of personal protective equipments (PPE) such as hazmat suits, N-95 masks, testing kits, ventilators and medicines. These shortages have been a major impediment in treating patients and have put health workers under severe pressure by increasing the risk of being infected. According to newspaperreports, more than a thousand doctors, nurses and paramedics have already been infected with Covid- 19 across Indiaand the numbers continue to increase. In addition, long working hours in the all-covering PPEs, inability to even have a cup of tea or water, or relieve themselves and reduced oxygen flow to the brain can have damaging effects on the health workers.

Apart from the increased risk of infection, the health workers are also susceptible to anxiety and stress about the safety of their family members, depression on seeing the traumatic conditions of their patients and fatigue and burnout due to prolonged shift. They are also increasingly facing social stigma and harassment. Several healthcare workers have been asked to vacate their rental accommodation due to the fear that they may carry the infection from their place of work to the society.

Disturbing videos and reports on the social media have been doing the rounds exposing the various deficiencies in COVID designated public hospitals in Mumbai. Print media has also published news items about nurses having quit their jobs at hospitals or just stopped reporting for work abruptly. State authorities have cracked the whip and threatened disciplinary action against erring doctors and nurses to get them to report for work.

Such a threatening posture does gross injustice to the already battered health workers especially in the public health system, who continue to work against all odds, putting their own lives at stake. Threatening action such as termination of services, delaying payment or deducting their salary when they are working round the clock in such vulnerable times will only demoralize them further and is more likely to exacerbate the problem than solve it. Recently, doctors have threatened to go on strike for non-payment of salaries for the last two- three months.

Such an emerging situation raises several ethical dilemmas. Can the state compel health workers to work, without first ensuring safe working conditions to discharge their duties? Paucity of protective gear, risk of assault, long working hours due to inadequate staff are all taking a toll on the health and lives of the health workers. While the workers have gone full throttle into the war against the virus, their efforts are being watered down by the demanding and inhuman treatment of the authorities, who instead of supporting them with real time assistance are goading them to breaking point. Is the state justified in endangering the lives of health workers while absolving itself of the responsibility of protecting them, while they are at work? Can the state be complacent in its responsibility to support the heath workers, while expecting them to do their jobs? To what extent can the life of health workers in the line of duty be compromised, in order to protect the life of the victims of the pandemic? To what extent can the right of the patient to get treatment be prioritised over the right of the health worker to safe working conditions? Does the personal call of duty ‘to serve the sick’ override all considerations including the safety of their own lives? Is it ethical on the part of the doctors to give a call for a strike in such distressing times, overlooking their own right to be paid their dues on time? Should there be a trade off between the lives of those affected during the pandemic and that of the health workers in the first place and should the state not be held accountable for its own failings? Is it ethical/ right on the part of the authorities to threaten them with action, in their frustration at not being able to handle the crisis, which is partly of their own making? Expenditure on public health system has never exceeded 2 percent of the GDP, with persistent demands to increase it falling on deaf ears over several decades. After years of protest by doctors and nurses, it took a pandemic to approve the Epidemic Diseases (Amendment) Ordinance, 2020, which seeks to protect healthcare professionals from attacks, making them cognizable and non-bailable offences. These are questions that need to be addressed so as not to compromise the rights of the health workers on the grounds that they have opted for such service out of their own volition. Survival and recovery of those affected hinges on the support provided to the health workers in the fight against the pandemic.

Historically, the nursing profession in India has been accorded a low status in society due to prevailing religious and societal norms. With reproduction and nurture being biologically linked to women, nursing has been a gendered profession, with more 70 percent of health workers being women. It has been a profession subordinate to and controlled by masculine medicine. Though the status of nurses has improved to some extent over time, their services continue to be undervalued and unrecognized. The extent of shortage of nurses and doctors can be understood in the light of the fact that the nurse-patient ratio in India is 1.7:1000 as compared to the ratio of 3:1000 recommended by W.H.O. Likewise, the doctor-patient ratio in India stands at 1:1445 as against the WHO recommended ratio of 1: 1000. A study estimated a shortfall of 2.4 million nurses in India and reported that 640,000 Indian nurses were working overseas in 2011. While international migration was part of the reason for this shortage, this migration was fuelled in the first place by unsatisfactory working conditions in the country. Further, reports indicating vacant seats in nursing colleges in South India are a matter of serious concern, indicating decline in enrolment for such courses. This development is likely to accentuate the existing shortage of nurses in existing healthcare institutions, which may have to be closed down if these shortages persist. However, absence of comprehensive and reliable database on the nursing workforce in India and emigration of Indian nurses poses a serious challenge towards generating a policy for improved health workforce planning.

With an increase in ageing population and non-communicable diseases in both developed and developing countries, shortage and inequitable distribution of health workers has for long been a global problem. A meeting of international health professionals in Dublin in late 2018 projected a shortfall of [18 million healthcare workers worldwide by 2030](http://www.who.int/hrh/events/4th-global-forum-hrh/en/). Developed countries have been trying to plug shortages in their economies through targeted recruitment drives with offers of better career opportunities, higher pay and an improved quality of life for nurses from developing countries. The loss of human resources in developing countries will further impede their ability to deliver health care equitably. This trend indicates a systemic collapse of the public health system on the one hand and declining access to healthcare services for a large majority of the population who may find it difficult to access for-profit private healthcare services. India is the second largest exporter of nurses after Philippines. It faces a double whammy with increasing shortage of health workers to meet its domestic demand for health services on the one hand and increasingly difficult working conditions which further push healthcare workers to seek early retirement or employment in other countries on the other.

Well trained health workers are the only human resources who can effectively utilize the health infrastructure in protecting and promoting the health of the people. Training health workers takes time and this calls for sustained long term investment in such capacity building. Humungous crisis like the present pandemic cannot create such skilled workers overnight to meet the sudden surge in the demand for their services. This is evident in the present crisis where though infrastructure in terms of facilities/ beds is being expanded to meet the rising number of positive cases, there are few health professionals available to man these facilities.

By bringing lives and livelihoods to a complete standstill, the pandemic and the resultant lockdown have clearly brought out the inextricable link between health and development: that no development can take place without good health. As Amartya Sen pointed out, ‘good health and economic prosperity tend to support each other’. We can afford to neglect our health workers only at our own peril.

The present outbreak is a wake-up call for governments across the world to strengthen their health infrastructure and recognize the vital role played bytheir health workers. This calls for urgent steps by governments to increase their investment in sustainable health infrastructure and support, protect and retain their health workers with better working conditions. It is indeed a sad reflection of our distorted value system that places health workers at the lowest rung of the remuneration pyramid in spite of being the pillars on which the superstructure of development is built. While the choice ‘to serve’ is indeed their own calling, we must not forget that by pushing them against the wall we will deny ourselves, the last hope of recovery. Time is running out and we need to act now if we are serious about protecting our health workers and in turn, our own lives.