

Social Inequities in Private Health Sector Workforce in India: Religion, Caste, Class, and Gender

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Abstract

The health workforce is hierarchical in structure in terms of skill mix and social composition. Most of the studies on the health workforce are focused on the number of personnel in the public sector. The private sector that has a large presence employs a significant percentage of the total health work force but there is little reliable data on the numbers involved. This is largely due to the lack of regulation of the private health services. Apart from the numbers involved in both the sectors, a few studies have shown the relationship between the work and social hierarchy in health services. While the public sector has a more diverse mix of social backgrounds due to affirmative policies, the private sector ownership is mostly dominated by an upper and middle caste-class combine. There is an under-representation of minorities and women as owners of private health services. The gendered nature of work is visible with the middle and lower rungs constituted by mostly women and men from lower caste-class combine. The terms of work, working conditions and wages paid for this category of workers amounts to exploitation with no forum for redressal. This essay draws together some primary work and references to secondary research and anecdotal evidences to build the scenario of social inequities among the workforce in the private health services.

Keywords

Health personnel – doctors, nurses, paramedics; permanent and temporary workers; occupational hierarchy; social inequity; caste; class; gender; religion; private health care

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Introduction

The estimates of healthcare workforce, from all past censuses and surveys has drawn attention to a significant deficit in all categories of workers, and a substantial urban bias in their geographical distribution. The analyses of these data sets have mainly focused on the public sector. Since the launch of the NRHM in 2005, the Indian government has engaged in increasing the training institutions for all categories of health personnel—doctors, nurses, technicians and other paramedics to close this gap. In order to increase supply of health personnel there has been an effort to establish medical, nursing and allied disciplines with the involvement of both the public and private sector. Recent data shows that the public to private ratio of medical colleges is almost equal at the all India level but there are state variations. The south and west states have a higher proportion of private medical colleges while the east and some north states have a higher proportion of public medical colleges (Baru and Diwate, 2022). However, all other categories of the health workforce are trained in private colleges across the country. The privatisation of nursing, technical, paramedical and allied health disciplines is widespread in India. There is however little effort for regulating the quality of those who are being trained. The gap in terms of self-regulation, accreditation and quality assurance is glaring for private medical, nursing, technical, paramedical and allied health disciplines that requires serious study and policy engagement.

However despite these efforts, recent research presents a rather grim picture on both the quantity and characteristics of healthcare workers in India. K D Rao employs three macro data sets to arrive at estimates of the different cadre of health workers. These include the Census, NSSO and Professional Councils. His analysis points to considerable variation in the availability and distribution of doctors and other cadre of health workers across states in India (Rao et al., 2011). A larger proportion of them are in the private sector across cadres (See Figure 7 as cited in Rao et al., 2014). Apart from a significant shortage in many categories of workers, a considerable proportion of personnel are unqualified, especially within the private sector and rural areas. Baru (2004) finds the private sector often hiring poorly qualified staff at paramedic levels who can be paid less, in order to contain costs. Even doctors with BAMS degrees are preferred over MBBS because they can be paid lesser salaries (Baru, 2004).

India has one of the most highly privatised healthcare systems in the world—both in terms of finance and delivery. In 1996, the private sector accounted for 54 per cent of rural hospitalization and 70 per cent of urban hospitalization. By 2000 the private sector included as much as 93 per cent of all hospitals and 64 per cent of all beds nationwide (Radwan, 2005). The private health sector is highly heterogeneous in nature with providers ranging from qualified specialists to unqualified persons and quacks, practicing different systems of medicine and healing forms, in highly diverse organisational setups (Baru, 2005). Early scholars documented concerns on the poor quality of care in the private sector. There were problems with diagnostic and treatment practices, inadequate facilities and equipment, malpractices like over prescribing and

unnecessary investigations, exorbitant charges, etc. (Nandraj et al., 2001). However despite the size and scale of the private sector, data on the private health sector and the personnel remains fragmented and under reported. Government sources record data for public sector personnel, but not for the private sector. Records for health personnel from other systems of medicine, like AYUSH also are also inadequate and largely self-reported. As a consequence, little is known about the structure and dynamics of the health workforce.

This essay seeks to pull together the magnitude, social characteristics and working conditions of healthcare employees in the private sector, through an extensive review of literature, primary data, relevant reports of civil society organisations and newspaper reports.

Methodology

The essay is based on an extensive literature review on the condition of health workers employed within the vast private health sector in India. The essay employs both secondary data and anecdotal evidence arising from primary studies conducted within private sector settings on the conditions for work. Owing to a dearth of data and information on the private health sector, the authors piece together evidences from small sample studies to arrive at a meaningful analysis. The study strives to understand these findings on the private sector work conditions along two axes—first, the work conditions within the public health sector, and second, the social background of these workers. A juxtaposition of the occupational hierarchy within health services along with the social hierarchy in terms of their religion, class, caste and gender of the workers, and the resultant dynamics of healthcare work in the private sector.

The sources of data for the essay are government reports, research publications, reports of civil society, e-newspapers, journals and periodicals. For newspaper reports and other published data, Google search engine, with specific search words like: “private sector staff India”, “caste and class of health workers in private hospitals”, “nurses in private hospitals”, “dearth of staff in Hospitals”, “nurses strikes in India”, “harassment in hospitals”, “caste background of nurses”, “ward boys and cleaning staff”, etc., were done. Search engines of few newspaper websites like the Times News Network, The Hindu, The Indian Express, The Hindustan Times were also used to locate older news clippings. The authors focussed on news articles published in the period post 2000. Further Digital library platforms offered by JSTOR and Google Scholar were used to derive research papers that engaged with facts and descriptions on work in the private sector. Apart from these two sources, Government of India Reports on Indian health workforce—like Census and NSS survey data was also utilised. WHO reports and papers were also consulted. Data collection from all these sources was conducted between 14 June 2021 and 31 January 2022.

Data and research on the private health sector in India has always been scanty. Not only is data not recorded, there is also a considerable effort from the private players to not share vital information about their services, protocols, processes, user charges,

number of service providers, etc. Accountability and monitoring mechanism by the government have been very weak. Efforts from private organisations and individual researchers to conduct studies and collect data from the private health sector are almost always met with considerable opposition and hindrance. As a consequence, very little information and data is available on private healthcare sector in India.

The studies on health workers in general are biased for the excessive representation of doctors and nurses. While studies on private sector employees are anyway very few, the existing work focuses primarily on doctors and nurses and does not pay adequate attention to allied staff that comprise technicians, physiotherapists, laboratory workers, pharmacists, nursing orderlies, cleaning and sanitation staff. The views and perceptions of these paramedics and ancillary workers are rarely recorded. Work on gender also omits another category of women workers consisting of helpers and ayahs. This comes as a serious drawback, as the authors found it very difficult to make an assessment on the caste and class background, and dynamics of working conditions of these health workers within the private sector.

The following paper discusses the dominant themes that emerged out of the literature review—namely a low density of qualified workers, the caste and class background of health personnel, low remuneration and forms of employment for different categories of health staff, feminisation of low paid work, sexual harassment at workplace, and weak unionisation of private sector employees.

Health Personnel in the Private Health Sector in India: Present Scenario and Concerns

Low Density of Qualified Health Workers

Authors Rao et al. (2016) quote data from a study using Census 2001 data which has estimated “the density per 10,000 population of all health workers as 20.1 (4.7 qualified), of allopathic doctors as ranging from 6.1 to 8.0 (2.6 qualified) and nurses and midwives as 6.1 (0.6 qualified)” (Anand S, Fan V. 2016 cited in Rao et al. 2016).¹ Comparing these figures with 2011-2012 NSS estimates, the authors found a density of 20.9 health workers per 10,000 population. The estimated densities by cadre were as follows: allopathic doctors as 5.8 (3.3 qualified); nurses and midwives as 7.6 (3.1 qualified); dentists as 0.4 (0.3 qualified); AYUSH practitioners as 1.3 (0.6 qualified); health associates² as 5.8 (1.8 qualified); and traditional practitioners as 0.1 (0.0

¹Authors Sudhir Anand and Victoria Fan (2016) provide data on health care personnel from Census 2001 using ‘density per lakh population’. Authors KD Rao, et al. (2016) convert the figures to ‘density per 10,000 population in order to facilitate comparison with other studies.

²The category of workers - health assistants and associates are engaged in administrative, managerial and other support activities. Health associates and assistants directly support other health workers involved in service delivery. This group (0.81 million as of January 2016) included health assistants, sanitarians, dieticians and nutritionists, optometrists and opticians, dental assistants, physiotherapy associates, pharmacist assistants, and so on. A second group – other support staff (1.25 million) included clerks, cashiers, tellers, housekeeping and restaurant

qualified) (Rao et al., 2016). A more recent study using NSSO 68th round data (July 2011-June 2012) estimated the density as 29 health workers per 10000 population. With educational adjustments this figure reduced to 16 per 10000 populations (Karan et al., 2019).

In a 2021 published study, Karan et al. use data from National Health Workforce Account (NHWA) 2018 and Periodic Labour Force Survey 2017–2018 of the National Sample Survey Office (NSSO) to find that

“stock density of doctor and nurses/midwives are 8.8 and 17.7, respectively, per 10,000 persons (all India). Adding the stock of dentists and traditional medicine practitioners to this gives a total stock density of 34.6 doctors per 10.000 persons for India. However, density of active workers (as estimated from the NSSO) of doctor and nurses/midwives (without adjusting for adequate qualification) is estimated to be 6.1 and 10.6, respectively. The density further drops to 5.0 and 6.0, respectively, after adjusting for the adequate qualifications. Total active worker density is estimated to be 26.5 and 16.7, respectively, before and after adjusting for qualifications.” The authors also add that “the density of allopathic doctors and nurses who are active in labour market are as low as 6.1 and 10.6, respectively, per 10,000 persons (16.7 in total), which is well below the WHO threshold of 44.5 doctors, nurses and midwives per 10,000 population.” (Karan A et al., 2021)

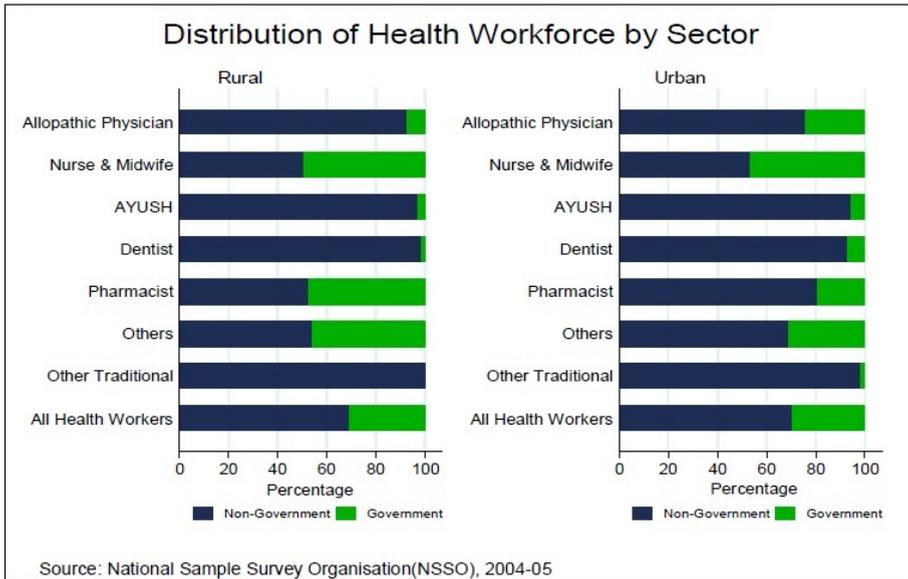
The health personnel data with its education adjustments highlighted the large presence of unqualified providers in India’s health workforce. Overall, there are 1.4 million unqualified health workers in India, representing 56.4 per cent of the health workforce. By cadre, this meant: 42.3 per cent of allopathic doctors, 58.4 per cent of nurses and midwives, 27.5 per cent of dentists, 56.1 per cent of AYUSH practitioners, and 69.2 per cent of health associates did not possess the necessary qualifications. Further, the presence of unqualified health workers is higher in rural (71.2 per cent) compared to urban (48.8 per cent) areas.³ The distribution of qualified health workers was also skewed towards urban areas; 77.4 per cent of all qualified workers were in urban areas, even though the urban population accounted for only 31 per cent of the total population (Rao et al., 2016).⁴

service workers, personal care, protective service staff, garbage collectors, other sanitation workers, and so on. These support staff perform crucial roles which are imbedded in the overall health service delivery.

³The weighted estimates for unqualified health workers in rural India were: 69.1 per cent of allopathic doctors, 68.2 per cent of nurses and midwives, 62.9 per cent of dentists, 74.3 per cent of AYUSH practitioners, and 75.8 per cent of health associates. Qualified female health workers constitute almost half of the qualified health workforce.

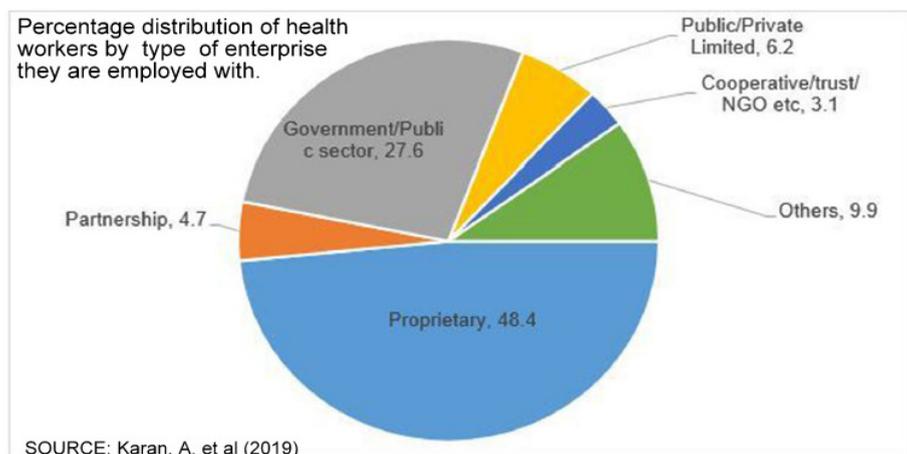
⁴The density of qualified health workers was 22.7 per 10,000 population in urban areas, as compared to 3.0 per 10,000 population in rural areas. The maldistribution was higher for allopathic doctors (density 11.4 times higher in urban areas), as compared to nurses and midwives (5.5 times higher in urban areas). Almost all the dentists were in urban areas.

While the above statistics are cumulative that includes the public and private sectors, available estimates show that the situation of private health sector is much worse. In both rural and urban areas, around 70 per cent of the health workers were privately employed in the nongovernment sector (rural, 67.0 per cent; urban, 74.0 per cent). More than 80 per cent of allopathic doctors in urban (87.1 per cent) and rural (83.5 per cent) areas were engaged in private employment. Similarly, more than 90 per cent of dentists (rural, 96.7 per cent; urban, 91.9 per cent) and AYUSH practitioners (rural, 95.5 per cent; urban, 93.9 per cent), and around 70 per cent of health associates in both rural (68.3 per cent) and urban (75.5 per cent) areas were working in the nongovernment sector. However, among nurses and midwives, 48.8 per cent of those in rural and 59.8 per cent of those in urban areas were privately engaged (Rao et al., 2016).



Source: Rao, K.D. (2011) Situation Analysis of the Health Workforce in India. Human Resources Technical Paper I. Public Health Foundation of India. New Delhi

In both rural and urban areas, around 70 per cent of the health workers were privately employed in the nongovernment sector (rural 67.0 per cent; urban 74.0 per cent) (Rao et al., 2016). Occupation-wise, the proportion of doctors employed in the private sector is far higher compared with nurse and midwife and other health workers. For AYUSH and dental practitioners, their share in the public sector is less than 10 per cent. However, approximately 45 per cent of trained nurses and midwives are employed in public sector institutions (Karan et al., 2019). The authors further elaborate on distribution of all health workers by types of institutions and find more than half (53 per cent) of workers are self-employed in sole proprietorship or partnership entity; and only 6 per cent in big corporate companies with public or private limited status (See chart) (Karan et al., 2019).



The macro analysis of big data sets does not provide insights into the structure, dynamics and the social composition of health workers in the private sector. The essay draws on small studies on the private sector to get a better understanding of the conditions of workers.

A study of private hospitals in Chennai highlighted the poor adherence to norms—both in terms of infrastructure and staff composition. The study pointed to a dearth of staff at all levels of the work hierarchy. It also highlighted the strong dependence of private hospitals on government doctors with a significant percentage of the latter acting as consultants in the former (Muraleedharan, 1999). An earlier study of private nursing homes in Hyderabad also showed the inter relationship between the public and private sector with a large proportion of government doctors acting as consultants in small and medium nursing homes. This resulted in diversion of patients from the public to private sector who had to pay for care (Baru, 1998). A study of 24 private hospitals in Mumbai (Nandraj, 1994) found that majority of hospitals employed unqualified staff. Only one had a postgraduate doctor, while ten hospitals had doctors trained in other systems of medicine (as quoted in Baru, 2004). Employing unqualified staff compromised the quality of care being provided in these hospitals. One would agree with Rao et al. (2016) who points to the dilemma of the complexity of dealing with unqualified providers. On the one hand they provide health care to populations that do not have access to qualified providers, while on the other hand, their lack of proper training becomes a source of concern.

Hierarchy in the Health Workforce in the Public and Private Sectors: Religion, Class, Caste and Gender

The available studies on the social characteristics of the workforce in health care are few and tend to provide a fragmented insight in both the public and private sectors. Analysing the World Health Survey (2003) by WHO and IIPS (2006) on Health Systems Performance Assessment, Duggal (2014) points out that while there is

some information on the class background of the households of physician, it does not provide information on religion or caste. The analysis of this data shows that the bottom or lowest three quintiles did not have a single physician whereas the top quintile accounted for 83 per cent of all physicians. When it comes to nurses, 61 per cent belonged to the top two quintiles while the bottom two quintiles had only 19 per cent. A higher proportion of the support health staff (37 per cent) belonged to the bottom quintile as compared to the physicians and nurses.

Duggal (2014) further examines 2001 census data for the caste background of health professionals, and finds that, “for physicians the variances from the proportion in the population for each social group is highly negatively skewed for the SCs and STs, the deficits being between 50 and 80 percent, but for the “Others” group it is in excess between 10 to 15 percent. Going down the hierarchy to nurses and paramedics the variances become narrower and one sees a few excess ratios for SC and ST, notably for the category of sanitarians and nursing/midwifery. For the ST, the nursing and midwifery categories surprisingly show a huge excess of over 100 percent. The author asserts that despite affirmative action policies the SC and ST have been unable to break the glass ceiling of the upper caste control over the health professions, especially physicians of all types.” (Duggal, 2014).

Sobin George’s study found that with the exception of associate professionals of nursing, midwifery and ASHAs, the share of Dalits among the hierarchy of work in the health sector is far below compared to other social groups. It is under-represented as a proportion to their total population in both rural and urban India. The health worker population ratio across social groups shows that only middle and upper caste has adequate and in some cases over representation among all health related professionals. These include general medical practitioners, specialists’ doctors, trained nurses, technicians and associated health staff. While the upper and middle castes constitute a little less than 24 per cent of the population in rural India, their share is 40 per cent in the occupational category of health professionals, 70 per cent in nursing professionals, 34 per cent in health associate professionals and 26 per cent in nursing and midwifery associate professional (George, 2015).

The other side of the story is the underrepresentation of certain social groups, especially SCs and STs. While STs and SCs have a population share of 11 and 21 per cent respectively in rural India, their corresponding shares in the category of health professional are 1.3 and 16.5 per cent respectively. In rural India, the under representation of SCs is found to be the highest in the nursing profession. Urban India also follows a similar trend of under representation of STs in all categories. For SCs it was most pronounced in the category of general and specialist doctors in urban areas. While the population share of SCs in urban India stands at a little less than 15 per cent, their share in the category of general and specialist doctors is only 5.5 per cent (George, 2015). In short, the data indicates that there is visible

over representation of middle and upper caste groups and under representation of lower castes and scheduled tribes across the work hierarchy of care providers such as doctors and nurses. The all India averages mask interstate variations in terms of social composition of the health workforce.

A study on earnings of nurses in Gujarat provided some trends on the class background of nurses. “On an index of assets owned by their households, 26 per cent of nurses working in private hospitals fell in the lowest quintile of asset ownership, compared to 10 per cent of permanent public sector nurses and 22 per cent of temporary public sector nurses” (Seth, 2017). Her study also showed that nurses who were able to secure a permanent government job had a very low percentage of SC and ST nurses in comparison to the private sector. “A wide range of earnings reported by similarly qualified and practiced nurses in this study suggests the presence of multiple labour markets for nurses in India.” (Seth, 2017).

While caste disaggregated data for other paramedics like technicians, nursing orderlies, pharmacists, ambulance drivers, etc., is very scanty, however, the above analysis shows how the health sector hierarchy mirrors the hierarchy in the social system, and there is a clear gradient in the entitlements and emoluments accessible to people from different castes and classes. The doctors belong to the upper and middle castes. Among the middle and lower rungs of the hierarchy consisting of nurses, paramedics and technicians is mostly dominated by middle castes in the public sector. However, one section of workers—whether in public or private sector is exclusively from the lower castes and marginalised groups, namely cleaning and sanitation work. A study by Society for Labour and Development with Delhi’s public health service employees noted “the dominance of upper castes among the physicians, while the lower castes were concentrated among occupations such as ward boys, sweepers, security personnel, *chowkidars*” (SLD, 2015).

Understanding the religious composition of healthcare workers is another challenge as data on this aspect is non-existent. Studies by Oomen (1978) and Madan (1980) on the public sector in health found that doctors were mainly upper caste Hindus. Minorities like Muslims and Christians were very few among the doctors (as quoted in Baru, 2005). A study of the private healthcare sector in Hyderabad (1998), where there is a considerable proportion of Muslims, did not find any significant representation among doctors. Majority of doctors were upper caste Hindus (Baru, 1998). This was broadly in concurrence with the status of employment of Muslims in the economy and social sectors. The Sachar committee report 2006 showed an acute exclusion of Muslims from the formal economy. Using NSS 61st round data, the percentage of regular salaried or wage non-agricultural workers employed within government and large private sector for Muslims was lower than all other Socio Religious Categories, even lower than SCs/STs and OBCs among Hindus.

Table 1: Percentage of Regular Salaried/Wage Non-Agricultural Workers in each SRC Employed in Government/Public & Large Private Sectors: 2004-05

SRCs	All		Male		Female		Urban		Rural	
	Govt	Pub/ Pvt Ltd	Govt	Pub/ Pvt Ltd	Govt	Pub/ Pvt Ltd	Govt	Pub/ Pvt Ltd	Govt	Pub/ Pvt Ltd
All	34.2	13.1	34	13.8	35.1	10.2	31.5	14.6	39.2	10.5
All Hindus	35.3	13.9	35.3	14.6	35.2	10.7	32.8	15.3	39.5	11.4
Hindus										
SCs/STs	39.4	9.5	41.3	9.4	32.4	9.9	36.7	8.7	42.9	10.5
OBCs	30.4	12.8	30.4	13.1	30.0	11.4	27.3	14.0	34.6	11.1
UC	37.4	17.1	36.4	18.6	41.7	10.6	35.2	18.8	43.2	12.5
Muslims	23.7	6.5	23.0	6.5	29.4	6.8	19.4	7.4	33.3	4.8
Other Minorities	35.8	12.8	35.1	14.8	37.6	8.0	32.0	16.5	41.8	7.1

Source: NSS 61st round, Schedule 10

While their representation within the health sector workforce is not analysed, statistics on composition of occupational groups showed the domination of Hindus, followed by Muslims and then other Minorities for the category of 'Physicians and surgeons' in both urban areas and rural areas. However for the category 'Nursing and Other Technicians', the proportion of Muslims was far lower than other Minorities. This implies that the participation of Muslims in healthcare workforce fares worse than SCs, STs, OBCs and other Minority groups.

Table 2: Percentage Distribution of All (Principal & Subsidiary) Workers by Two Digit Occupational Groups for Each SRCs, 2004-05

Occupational Group	All	Hindus				Muslims	Other Minorities
		All Hindus	SCs/ STs	OBCs	UC		
Urban Workers							
Physicians & Surgeons, (Allopathic, Dental & Veterinary Surgeons)	0.6	0.7	0.3	0.4	1.1	0.5	0.4
Nursing & Other Medical & Health Technicians	0.8	0.7	0.8	0.5	0.7	0.6	2.5
Rural Workers							
Physicians & Surgeons, (Allopathic, Dental & Veterinary Surgeons)	0.2	0.1	0.1	0.1	0.3	0.2	0.2
Nursing & Other Medical & Health Technicians	0.2	0.2	0.1	0.2	0.3	0.1	0.3

The representation of Christians in the healthcare workforce is also very limited. Christians formed the bulk of nurses in early years, when both Hindu and Muslim women did not enter the profession. However, the remuneration of these nurses was very low, and they belonged to the lower socio economic strata (Baru, 2005). The author notes "they were predominantly Christian and were motivated by the need to serve humanity. The proportion of Muslims, SCs and STs among nurses was indeed very small" (Baru, 2005). However in recent years, with better remuneration, the participation of Hindu women has increased. Lower caste Hindu women were always dominant among untrained caregivers. Using data from Enterprise Survey 1996, Baru notes that "females belonging to Scheduled Caste category dominate the individually owned enterprises in health in rural areas. These largely included trained and untrained workers like dais who are traditional birth attendants and other healers." (Baru, 2005).

Among ANMs, Iyer et al. (1995) note that two-thirds belonged to upper and middle class Hindus, while SC and STs constituted only one-fifth of workers. A very small proportion comes from Muslims and Christians (as quoted in Baru, 2005).

For other categories of workers, religion-based disaggregated data is unavailable. Yet, the above trends affirm that Hindus dominate the profession of doctors, nurses

and technical staff. Christians show a better representation among nurses but little among doctors, technical staff, and other paramedic workers. The Muslims have a very low presence among all categories of health workers, and data on private sector employees—who are temporary and untrained remains unavailable to analyse.

Underpaid and Overworked

The remuneration paid by the private health sector has no benchmarks or predefined standards. Different organisations pay different scales to the workers, which are very low in comparison to the scales paid by the public sector. The women in particular face discrimination and disadvantages in wage, due to hierarchical structures and gender stereotypes that shape occupational segregation (WHO, 2019).

Patil et al. (2012) study on working conditions in public and private hospitals of Satara city found significant disadvantages for the private sector workers. Data on salary drawn by public and private sector employees showed that for all categories of workers, the average salary drawn by private hospital employees was 4.56 times lower than average salary drawn by government hospital employees. While government employees were entitled to casual leave, sick leave, paid and maternity leave, none of these were available to the private sector employees. Provident fund, gratuity and family pension were benefits only accruing to government sector employees, and private sector had no such social security provisions.

A study of nurses in Gujarat reported that 49 per cent of nurses working in private hospitals and as temporary employees in public facilities—belong to the Scheduled Castes and Scheduled Tribes, and were estimated to earn 9 per cent less than similarly qualified and practiced nurses from general caste categories. Further 18 per cent of nurses working in private hospitals did not have formal nursing qualifications. And last, nurses working in private hospitals and as temporary employees in public facilities earned less than the minimum wage stipulated by the Government of India.

The same study also finds that “permanent public sector nurses were estimated to earn 105 percent more than private sector nurses with the same qualifications, years of work and caste background.” (Seth, 2017) These findings resonate with the general trend of exploitation of workers within the private sector across the hierarchy, the lowest rungs suffering the most. Understaffing has direct implications on workload, and this coupled with being underpaid manifests in extreme exploitation of workers, especially within small hospitals and polyclinics. The corporate and bigger private hospitals still adhere to the minimum standards laid by WHO owing to better accountability from the government, and remuneration standards are much better. However, they represent a miniscule proportion of the private sector.

In 2010, nurses from top private hospitals in Delhi held protest strikes against their employer and the Government. This was against significant wage differentials in the public and private sector. “While the salary offered to a fresh nurse in a public sector hospital before the implementation of the Sixth Pay Commission recommendations was in the basic scale of ₹ 5,500, the total salary of a nurse in a private hospital

who has completed the general nursing-midwifery degree⁵ (which takes 3 and half years after 10+2 years of schooling) ranges anywhere from ₹ 2,500 to ₹ 6,000. The difference is all the more glaring after the implementation of the Sixth Pay Commission recommendations in public sector hospitals, and has triggered the current wave of strikes” (Nair, 2010).

The for-profit private sector uses the strategy of paying lower incomes to staff in order to increase profits. In pursuit, practices like understaffing, replacing trained and qualified nurses with under-qualified personnel is common. Sreelekha Nair (2010) observes that many small private hospitals pay nurses less than the minimum wage and flout regulations regarding employment benefits and leave packages. Nurses are being replaced by nursing aides, auxiliary nurses and untrained assistants, who can be paid just ₹ 1,000 to ₹ 1,500 and are made to perform nursing duties including giving injections for which they are not trained. The working conditions for nurses can also be very challenging with adverse nurse-patient ratios of 1:30 to 1:50 in the private sector. Facilities like restrooms and changing rooms are also not provided in most private settings.

A nurse activist observes that “most of India’s nurses work in private hospitals, which are largely unregulated and do not follow the norm of having nurse-patient ratios of one to every four. Nurses work 9 to 14-hour days, often doing double shifts. Many nurses are required to sign contractual bonds with their employers withholding their educational certificates as guarantee” (Mahindrakar, 2016). Withholding of certificates is a common practise in private hospitals to prevent the trained and qualified nurses from leaving the job, and treat them like bonded labour. Biju explains this practise often stems out of desperation to earn soon as many nursing students take loans to complete their education. With a decline in opportunities in the public sector, private hospitals have cashed in on the opportunity to adopt exploitative practices. They often ask candidates to execute service bonds and deposit ₹ 25000 – ₹ 75000 at the time of joining service. The management also impounds original certificates to prevent inter-firm migration. Often they are paid only part salaries which also is also given irregularly (Biju, 2013).

Thus, most nurses in the private sector have to contend with lower wage rates and a lack of job security. They are commonly employed on temporary contracts, which are renewed every time the contract expires. Such mechanisms allow the private hospitals to push these specialised and trained workers into the non-formal economy, devoid of rightful incomes and upward mobility. Legislative attempts to standardize private medical care have also been opposed by many states and powerful professional bodies, such as the Indian Medical Association. For instance, the Clinical Establishment Act of 2010—which prescribes minimum standards for services to be provided by a variety

⁵General Nursing and Midwifery (GNM) and Bachelor of Science in Nursing (BSN) are the two main nurse training programs in India, and their graduates are generally employed as A-grade staff nurses in hospitals. Auxiliary Nursing and Midwifery (ANM) is a shorter, 2-year certificate course whose graduates assist A-grade nurses in hospitals or work in public primary health facilities.

of clinical establishments and requires private clinical establishments to register with the state, maintain records of the care they provide and display rates of the services they offer—has only been adopted by few states (Seth, 2017). These practices are not restricted to small and medium nursing homes but it is also seen in the corporate hospitals across states.

Corporatisation and privatisation of healthcare has led to further exploitation of nurses and nursing ancillary staff. With international immigration, there has been a supply crunch in nursing labour. The scarcity of registered nurses, instead of valorising nursing labour, has led to an increase in the hiring of unregistered nurses, nursing aides and attendants. Whether it is the public or the private sector, there is a growing reliance on a pool of semi- or untrained labour that represents the most informal and casual end of the workforce. The nursing labour market is a pyramidal market with the bottom over-represented by female casual employees struggling with low wages and status, stigma, and no labour rights (Ray, 2020).

The condition of other workers like technicians, paramedics, cleaning and sanitation staff, ambulance drivers, among others is no better. They are hired as temporary workers, and paid a very low remuneration, irrespective of whether qualified and experienced. But more glaring are the consequences of understaffing, owing to which most of these staff are multi-tasking, and fulfilling any roles where a need is felt—whether or not they are trained. A newspaper report on shortage of paramedics revealed that a sanitation worker would bandage patients, plaster casts and even worked in the laboratory, besides his own cleaning work.

“It is not part of my duty, but a cleaner’s work is not hectic. And there is a major shortage of paramedic staff, particularly at nights, so we help the doctors and laboratory staffs,” he says (Singh, 15 January 2014).

The union of paramedics claim that although official data is missing, but approximately 70 per cent paramedics in the country are not trained for the jobs they do (Singh, 15 January 2014). “Such cases of multitasking by paramedics is a very common sight, and untrained workers are doing paramedics’ work in most government and private hospitals in the country, in the words of union activists.”⁶ A survey by Health Ministry’s National Initiative for Allied Health Sciences and the Public Health Foundation of India in December 2012 also highlighted the acute shortage of qualified paramedic staff in the country. Health activists and doctors blame the lack of a comprehensive Central legislation to monitor paramedics for the present situation. “They say in the absence of a Central law, there are no standard minimum qualifications for the appointment of paramedics such as nursing assistants, laboratory assistants, compounders, X-ray assistants, etc. To make matters worse, only five states have set up paramedic councils for drafting standards for education in the sector. Few among these are also very nascent. In such a scenario, it is left to health centres and laboratories to appoint paramedics and decide their qualifications.” (Singh, 15 January 2014).

⁶Kaptan Singh Sehrawat, the then general secretary of the Joint Forum of Medical Technologists of India (JFMTI), an umbrella body of paramedics in the country, as quoted by Jyotsna Singh in ‘Down to Earth’ (2014)

But health activists also warn of the negatives of having a pool of qualified paramedics, because despite being qualified, it might not result in private hospitals and labs recruiting them. Singh's study quotes a union leader as saying: "What will the degree holders do if there are no takers? Those who are unskilled or less skilled are ready to work at a much lower wage, while the skilled demand more money. Recruiters, especially private bodies, do not care about skills" (Singh, 15 January 2014). Thus, it leads to greater frustration among the graduates and they are trapped in the cycle of exploitation and low remuneration. Owing to the significant outreach of the private sector, it has also led to mushrooming of ill-equipped private institutes across the country often on false promises of government jobs. This is also the case with nursing institutes and pharma courses. Non accredited institutes offer degrees which are not recognised, and their graduates are ineligible for work within any big hospital. They thus get employed at very low salaries by smaller hospitals and clinics, and with exploitative conditions. Regulating private institutes is also now an imminent challenge, but union activists say: "Steps to strengthen the education system will not help unless there are rules to govern recruitment." (Singh, 15 January 2014).

Similar ethos was seen in a study on motivational level of physiotherapists in four cities of north India. The two dimensions which had the highest scores were salary and job security. Two other interesting findings were greater satisfaction levels among male workers compared to women, and among higher qualified physiotherapists in comparison to others (Gupta et al., 2013). The study however failed to give any explanations for these differences, and comparison between public and private sector employees, despite having collected responses from both settings. The Pharmacist is another crucial worker in the health system who dispenses medicines, however this task is mostly done by a supporting person who is less qualified. Sabde's study on Private Pharmacies in state of Madhya Pradesh revealed interesting facts—one, only 12 per cent pharmacists had the minimum formal qualification; and two, 88 per cent of these qualified persons worked in urban areas. Sabde warns that poor education of dispensing pharmacists has been identified as a leading cause of irrational use of antibiotics. The prevalent perspective about pharmacists is never as health professionals, rather as traders (Sabde, 2011).

The situation of cleaning and sanitation workers, the nursing orderlies, and ambulance drivers (also referred as ancillary workers) are quite similar across both private and public sector owing to outsourcing. Even if the site of work is a public facility, the workers from these categories are supplied by a private contractor. This implies, almost all workers in these professions are engaged in the private economy. A report by Workers Solidarity (2000) on the private hospitals in Delhi noted the trend of hiring contract workers initiated by new private sector hospitals. The report also cautioned how the practise was also being emulated by older private hospitals, which until had offered permanent employment to Grade 4, namely, sweepers and security guards. The report noted that contracted staff were overworked—to the extent of doing 5 consecutive shifts owing to shortage of staff, poor salaries, constant job insecurity and no provisions for lunch time. The report also noted how contracted workers were fired

since they had complained to the Labour Commissioner. The contractors were reported to change the posting of these employees in order to prevent them from collectivising and forming unions (Worker Solidarity, 2000). A study on outsourcing within a tertiary public hospital in Kolkata, West Bengal showed the flouting of minimum wages by the contracting agency when remunerating cleanliness staff. The interviews also exposed delayed remuneration to these workers, and a denial of protective gear from infections owing to exposure of hospital waste (Roy, 2010).

Sexual Harassment and Feminisation of Work

The nurses form the largest category of hospital employees. Approximately 70 per cent of nurses, midwives and community health workers are female; the share of female doctors is much lower than a third. Female doctors comprise only 17 per cent of the doctors in the country (Rao, 2014). A WHO report records the adverse occupational gendering in healthcare: across countries, most physicians, dentists and pharmacists are men, while women are overrepresented in the ranks of nurses and midwives. The same report records that women health workers earn on an average 28 per cent less than men (Ray, 2020). The health sector is a highly gendered space, where women historically have been relegated to a secondary status. The realm of doctors, which is dominated by men, is seen as the ‘cure’ part, while nursing which is dominated by women, is seen as the ‘care’ aspect of healthcare practise. The task of nursing is usually seen as more caring than curing, an extension of stereotypical feminine qualities (Ray, 2020). Gender bias in healthcare is seen with respect to specialities like cardiology and surgery viewed as male bastions, while gynaecology and microbiology are regarded as more women-friendly. The private sector is mainly dominated by male doctors-turned-entrepreneurs. A study of private nursing homes in Hyderabad revealed that the medium and small nursing homes are promoted by spouses who are doctors. Here, again it is the husband who is the main owner while the wife occupies a secondary position in the partnership. The private and public limited enterprises are mostly promoted by male entrepreneurs. It is in only in family promoted enterprises where there are no male heirs, that daughters are allowed to manage the company as seen in the case of Apollo Hospital promoted by Dr Pratap Reddy.

The nursing profession on the other hand is dominated by women. The division between curing and caring is clearly gendered. The feminisation of the health workforce begins with the nurses and is seen in the lower rungs of the work hierarchy in both public and private hospitals. This hierarchical opposition reinforces a nurse’s secondary role within health institutions. The secondary role is further reflected in the gendered wage gap and adverse working conditions. Stereotypes of nursing as natural female, caste norms and various stigma reinforce the low valuation of care work (Wichterich, 2020).

The historical and sociological literature suggests that the low wages nurses are paid in India might be a reflection of their low status in the health system and society. Studies conducted in other countries, such as Mexico, Bangladesh and the US, also document the prevalence of negative gender and class-based dynamics in the work

environment of nurses (Seth, 2017). Shelby Garner, et al. (2014) explain how historical religious and cultural factors have shaped the attitudes about nursing among society in India thus contributing to the limited nursing workforce capacity. The work of women outside of the home that involved touching strangers and exposing them to potentially infectious materials was viewed as “polluting within Hindu and Muslim Cosmology”. As a consequence, nursing was relegated as a low caste position, and early nurses in India saw a predominance of Christian women.

Studies on the rise of nursing profession in India note that a shortage in the number of trained nurses was on account of a highly negative and sexualised image of the nurse. “In the beginning, a nurse was considered a prostitute or an assistant of a doctor in a clinic or a small hospital, expected to perform non-nursing duties, work that was menial and intensive physical work, including night duties, within unsatisfactory and crowded living conditions making it highly unattractive...low standards of education among those who went for a nursing job made it unattractive in the eyes of the educated. These notions culminated into a relatively low status of nurses in the health care hierarchy and the visible dominance and even harassment by power-wielding male doctors that have engendered a social stereotype of women who work as nurses” (Abraham, 2004). These stereotypes get reflected in workspace as well. Studies have shown that a high percentage of nurses in India are women who face sexual harassment and lack of physical safety as a part of the poor working conditions that they face (Seth, 2017).

Chaudhuri’s study (2007) found sexual harassment routinised in the everyday lives of the women health workers, especially nurses. The women who had experienced harassment were reluctant to complain, fearing loss of jobs or being stigmatised, and most were not aware of formal channels for redress. The perpetrators could be anyone in the hospital—fellow male doctors, persons in administration, and even patients and their relatives. The author analysed such violence embedded in patriarchal gender inequities, which even superseded other power relationships, e.g. in the case of male patients or administrative staff harassing nurses, young male doctors harassing their female colleagues or non-medical staff such as stewards, sweepers, peons and ward boys harassing their female peers.

The study also highlighted that very few cases of sexual harassment were actually reported. Victims were scared to confront the system, since social norms inadvertently placed the blame on the victims. Further, recognition of power dynamics and the implications in terms of job security, loss of reputation and risk of dismissal also suppressed the women from seeking justice. This exposes the power imbalance even in spaces where numerically women are higher, and shoulder a significant responsibility. Respondents were well aware that if the perpetrator was a person in authority, action was unlikely to be taken against him. Many reported fear of dismissal, loss of income, blocking of promotion and victimisation in work assignments (for example, inconvenient duty hours). These fears are greatly magnified if the women worker is on temporary post or working on contract, unfortunately the norm in private sector.

Basu (2020) writes about the extreme exploitation of *ayas*—another category of care providers whose numbers have increased more than the nurses, however their remuneration and emoluments continue to be very low and exploitative. The study based on private health sector in Siliguri, West Bengal notes the transformation of nursing homes to limited companies owing to mergers and acquisitions by corporate giants, however, labour relations continuing to be informal especially for care workers who remain semi or unskilled. The remuneration paid to *ayas* was found to be determined by multiple stakeholders like the hospital management which fixed the wage rate, however, the amount was paid by the patients' families. The daily wage rate ranged between ₹ 150 to ₹ 170, with the exception of a super speciality hospitals where they received a monthly salary of ₹ 3200 (Basu, 2020).

Recent strikes and protests have been the only channel through which some benefits have accrued to these strata of workers. While unionisation of these workers was long non-existent, the nurses were earliest to collectivise, paramedics and outsourced staff have more nascent unions. Biju explains—as nursing services have been commercialised over the past two decades, thousands of nursing institutes emerged between 2002 and 2005, especially in the southern states. Many young nurses formed associations such as the Indian Professional Nurses Association, Delhi Private Nurses Association, and the United Nurses Association to demand better working conditions. In May 2015, there was attempt to unite all nursing associations of India (Biju, 2013). The unionisation of nurses in Kerala's private sector, and their subsequent success in increasing wages forced corporate hospitals in Delhi, Hyderabad and Chennai to announce new pay packages, in order to prevent the exodus of nurses back to Kerala. However union activities are never given space in the private sector, and many times workers had to face the brunt of organising protests. In December 2009, staff nurses of the Batra Hospital in New Delhi went on strike demanding basic facilities and minimum basic salary of between ₹ 10,000 and ₹ 15,000. They succeeded in getting the salary hike but those nurses at the forefront were fired on disciplinary grounds. In the public sector, nurses protesting working conditions are sometimes sent to difficult locations or may be refused leave (Mahindrakar, 2016).

A study of Delhi private hospitals showed that only 30 per cent of their expenditure was on salaries, while in public hospitals, it was close to 80 per cent. Even the meagre 30 per cent mainly goes to the consultants who have higher salaries in the private sector. The proportion of wages paid to consultants has shot up over the years, due to which adequate pay scales due to paramedic and support staff is not paid. And consequently much of the class 4 has been contracted out (Baru, 2004).

Conclusion

Drawing on a variety of research articles and primary work on the private sector, this essay has shown the complex intersection between the social and work hierarchy in secondary and tertiary health service institutions. The available studies on social background of health workers in public and private hospitals are few and mostly in

urban areas. While there is a recognition of the gender division in the hierarchy of work, there is little focus on religion, caste and class. Religious backgrounds are not foregrounded adequately especially with respect to representation of minorities. It is quite clear that majority of owners in the private sector are Hindus belonging to the upper and middle castes and male. However the nursing, paramedical and support staff constitute diversity in terms of religion, caste and class. The over representation of marginalised groups in these categories is higher in the private sector as compared to the public sector. This is largely due to the hiring of personnel who are semi or unqualified by the private sector as a means to save labour costs with exploitative terms of work. Poor wages, long hours of work, lack of secure employment, leave and pension benefits are glaring for the lower levels in the work hierarchy in the private sector. These practices amount to extractivism as discussed by Wichterich (2020). As she opines: “The notion of extractivism marks the intensified commodification and exploitation of the resource labour in social reproduction for the purpose of managing crises situations without burdening the state or the health industry with additional costs and responsibilities. It is a mode of accumulation in markets of social reproduction and health. While the deflated term exploitation highlights the offender–victim relationship, the concept of extractivism stresses the structural power relation in the political economy.” (Wichterich, 2020). The term aptly defines the case with much of the private health sector in India that thrives on the vulnerability inflicting the majority of labour force, in addition to the nurses. Workers from lower caste and class background, who are often not adequately qualified, bear the brunt as they are deemed unfit for well remunerative jobs. Formal jobs in professions of paramedics (barring some nurses and few technician roles) are fast converting into contracted and non formal jobs, where an outsourcing partner hires the workers on temporary terms. The exploitation is higher in smaller cities and rural areas, where no alternatives for employment exist. This exploitative system thrives on non interference by the government agencies, particularly the health ministry, which should ideally be setting standards of workplace compliance and remuneration standards in accordance with qualifications. Far from any accountability and compliance system, the government has also adopted contracting in of health workers thereby displacing recruitment of permanent ones.

The Covid-19 pandemic has brought considerable focus on the further exploitation of health workers in both the public and private sectors. The role of the unions has been very prominent in speaking against the oppression within the system. There have been numerous attempts by nursing unions, unions of ambulance drivers, and paramedics to pressurize the governments in enforcing workers’ rights for minimum wages, better working conditions and social security from the contracting agencies. The response from the government has been weak and half-hearted. Despite the Covid-19 pandemic the government’s stance to improve working conditions and wages of the health workforce is wanting. A news article published in April 2021

reported that “private ambulance network StanPlus was reported to be handling ten times more volumes of work since the preceding month of March 2021 and could find only one trained personnel for every four open paramedic positions, and was hiring paramedics staff at almost 50 per cent pay hike.” This demand surge came from more Covid care centres being commissioned and Home ICU setups being offered. (TNN, 30 April 2021)

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