Labour Dynamics and Heterogeneity of the Health Workforce in India: Cleavages Within and Without

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The labour market characterizing the health care sector, as in most other sectors, is the result of the interplay of two independent economic forces namely, the supply and demand for health workers. Interestingly, these labour markets also determine the geographical location as well as employment settings of the health care workers (Scheffler,2012). In the low and middle-income countries, the focus of the health workforce policies has been on increasing the number of health workers to meet the needs of the population and on training them. However, the employment conditions are not in place to absorb the workforce, and hence there is a risk of increase in unemployment and wasting of resources (Sousa et al., 2014). There is no reliable data source giving the segmentation of the health workforce as half of the health care professionals work in the unorganized private sector (GOI,2018).

This change in the landscape of the health workers started from the last decade of the twentieth century. During this period new roles and occupations emerged to meet healthcare market demand for services (McPake et al.,2015). With a lessened stake of government and increased control of the private sector players in India, provisioning of health care was affected. Questions were raised on the accountability of the services provided and rising out of pocket expenditures in health. The change in the nature of employment became more pronounced with the institution of the Structural Adjustment Program (SAP) which has been ubiquitous between 1980 and 2014; one of the major objectives of SAP was enabling market forces by withdrawing labour market regulations (Foster et al; 2019).

The direct effect of SAP was a reduction in subsidies to health services leading in turn to rapid decline in replacement and recruitment of regular staff in public health establishments (Peabody,1996). From the 1980s the growing skepticism about the efficiency of the public health sector in India, combined with increased questioning of the fraction of the health budget spent on the salary of the health workforce (which was around 80 percent of the total health budget) (Basu,2016) created a conducive environment to cut down on the government's expenditure on health and increase in investment by non-governmental agencies (GOI,1983).

A related phenomenon was the opening up of public health care to private investment and intervention. Casualisation of paramedical workers, hiring private sector doctors on contract and introducing public private partnerships for health programmes and institutions has grown alongside concomitant reduction in support to the public sector. New Public Management[1] accompanying SAP introduced reforms that heavily influenced the service specifications, purchaser provider split, and contracts, creating internal markets within public institutions and systems (Vabo,2009). Worse, private sector involvement was made to appear as the vital saviour of the resource crunched public health sector, of which contracting was seen as one of the dominant tools in engaging the private sector in health care reforms (Raman & Bjorkman,2009).

Contract work segmented the labour market, dividing the workforce into permanent and non-permanent workers. The appointments of temporary health workers have been defended on the ground that hiring regular staff is a time-consuming process which compromises health care work (Basu, 2016). Contract labour is not homogeneous; there are different types of such labour. These include: fixed term contracts where the hospital administration directly pays the workers who are hired for a fixed term; daily wage workers who are hired and paid directly by hospital administration; contracting out where services are outsourced to a service provider and a second form of sub- contracting where workers are supplied by the labour intermediaries, who are paid by contractors and the hospital administration pays the labour intermediaries (Thresia,2016).

The implications of the market logic of contractualisation applied to healthcare can be felt at multiple levels. At the workers' level wage theft, improper working conditions and employment insecurity are a part of informal employment (GHW,2017). At the level of the health system, due to less skilled and less committed workforce the quality of services gets compromised resulting in poor health outcomes and loss of patients' trust in the system (Basu,2016). Also, poorly qualified and paid persons such as paramedics are hired which cuts the costs and maximises the profits for private sector, eroding the quality of care provided (Baru,2004). A study conducted in Chandigarh deduced that the contractual health workers are less satisfied with their jobs due to lower wages and absence of job security than the permanent workers. It recommended that the level of satisfaction has to be enhanced in order to increase the effectiveness and efficiency of health care services (Dixit, Goyal & Sharma,2017). Comparable observations have been made regarding the contract workers working for Tuberculosis Control Program in Mumbai (Bisht, 2020).

While the impact of economic restructuring on the intensification of informal labour markets in general has been recognised, the parallel

emergence of flexible labour markets created by new forms of the healthcare industry and services has received relatively less attention. Today, a vast array of casual, contract, temporary, part time healthcare workers, fill the lowermost ranks of the health services. The lowest cadre comprises the outreach worker known as Community Health Worker (CHW), Community Health Volunteer (CHV), Accredited Social Health Activist (ASHA), and is disproportionately composed of women. Today the concept of CHV has been pulled out of the old seventies' context of Rural Primary Health Care services, and adapted to a new privatised and NGOised context of health care delivery.

In addition, the health workforce is gendered and skewed mostly towards the nursing and midwife professions; in fact, the female health workforce outnumbers males by five times. Far fewer women are employed as physicians. On the other hand, the male physicians are almost five times in number than female physicians in India (Anand & Fan,2016, p.15). Apart from being gendered, the class/caste character of this workforce has also been highlighted in the joint report prepared by WHO and Women in Global Health (2019).

Among the allopathic doctors there are some specialties in which women doctors continue to be underrepresented. According to the Association of Women Surgeons of India, out of 25,000 surgeons only 700 are women. The presence of women is largely concentrated around the "soft specialties" of Gynecology and Obstetrics, Pediatrics, Dermatology and Psychiatry. The branches of cardiologists, surgeons, anesthesiologists and orthopedic surgeons remain male dominated (Jain, 2018).

Nurses are largely employed in the private hospitals on contractual basis. The private sector guards itself against stipulations laid down in the Contract Labour Act by employing them for less than stipulated period and reemploying them through fresh lease of contracts (Nair et al., 2016). The lower wages and shorter contracts of nurses in the private hospitals might reflect the demand of the labour market for semi-skilled nursing professionals, who are hired to perform specific non-specialist tasks (McPake et al., 2015), thus maximising profits for the private sector.

As far as the lower rung of the workforce is concerned, there were 56,263 male health workers as compared to 2,20,707 female health workers (ANMs) in rural India in 2016. On the other hand, there were 12,288 male health assistants compared to 14,267 female health assistants (LHVs) in rural India in 2015 (GOI, 2018, p.226). Health assistants are entrusted with the task of supervising health workers; therefore, they stand senior to health workers in the hierarchical public health system (Ganguly & Garg, 2013). While it may appear that gender divisions are less pronounced in the health assistants' cadre when compared to the health workers' cadre, it needs to be noted that male health assistants have the responsibility of supervising a lesser number of male health workers when compared to the responsibility devolving on female health assistants. This is but one example of the disproportionate burden shouldered by one gender even when working in the same job cadre, female health assistants in this case.

Overall and across the country, with some minor variations in remuneration amounts, the lot of the community health workers in India (mostly women) is characterized by increase in tasks and consequent responsibility, payment not being commensurate with responsibility and thus leading to undervaluation of their work and role in healthcare of the community. It is important to note that the majority of these women belong to lower class/caste or both, a significant reason also being that those from upper castes would rarely participate in such care work outside their houses.

Health being a state subject, there is considerable variation in pay *within* and *among* the women health workforce of the different states in India. For example, the ASHAs in Kerala are provided a minimum of Rupees 4500 under the nine head incentive as established by the state apart from a consolidated remuneration of Rupees 2000. Additionally, there is a very strong union to voice the concerns of the ASHA workers, which vehemently puts forward the concerns of workers when required – rarely seen in other states. Kerala however pays its Anganwadi workers (AWW) Rs. 10, 000 per month. Across states, AWWs in Maharashtra are paid Rs.7000 per month, while Haryana has raised their total honorarium to 11,400 per month, the highest in the country. Anganwadi *helpers* on the other hand, and everywhere, are paid half the amount of the Anganwadi workers although they also work full time six days in a week (Johari, 2018). Like most informal workers of the country, most of the work as well as the bulk of the workers themselves are not covered as 'workers' in official databases.

Heterogeneity of experiences of women health workforce: Some Vignettes

A study conducted in Gujarat found that the nurses in the private sector as well as those in temporary appointment in public sector are likely to be younger, from SC or ST groups and from relatively poorer and less educated households. Additionally, permanent workers in public sector earned 105% more than nurses in private sector despite having same qualification, years of work and of similar caste. Further, nurses in private hospitals and those on temporary posts in public hospitals were paid less than the minimum wages stipulated by Government of India. (Seth,2017)

Another research on ASHAs from Manipur found that the irregular and meagre incentives given to ASHA workers resulted in pressures from their families especially husbands, who asked them to discontinue their work. So, they engaged in other economic activities, neglecting their professional roles. Further, within the community, ASHA workers constantly compared their role with the AWW who receive higher and fixed incentives. The study documented that a number of ASHA workers were politically appointed in the hope of getting a permanent job of AWW. Thus, discriminatory practices characterize recruitment even at the lowest cadre of health workers. The existing gendered notions of masculinity and feminity continue to affect the work environment of ASHAs, who are constantly rebuked for not taking care of their own families (Sapril et al.,2015).

Interestingly, having superior educational qualifications as in the case of doctors, doesn't change the way males perceive women health workers. In addition, the disclosure of work place violence may give an impression that women are intolerant and bad mouth unnecessarily. They suffer physical and sexual violence not only at the hands of their male counterparts but also from male patients and their attendants (Devasthali & Rege,2012).

Thus, changes in the labour market and the reorganization of the health sector have led to irregularization of the health workforce. This has adversely impacted the capabilities and capacities of health workers, especially women who have been unable to explore their potential fully. The need of the hour is to create a robust health system which is responsive (Bisht & Menon,2020) and locates the health policies within these dynamics to chart out a clearer and comprehensive process to address the cleavages within the health workforce in India. Merely lamenting the rise and profit-orientation of the private health and healthcare sector without addressing the ills afflicting the public healthcare sector, in which the creation and retention of a decent workforce is central, is futile, to say the least.

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Endnote

1. New Public Management is the name given to the strategy to introduce privatized management strategies such as customer orientation, incentives, individual accountability, etc., to government bureaucracies. The aim is to make bureaucracies more businesslike. (Editors)

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