Nurses and Unionisation: What Lessons Can We Draw from the Covid-19 Pandemic?

Richa Chintan[1], Susana Barria[2], Ipsha Chaand[3], Indira Chakravarthi[3], Banaani Deka[2], Santosh Mahindrakar[1], Dilip Mairembam[4], and Rupa Prasad[3]

(1-Jan Swasthya Abhiyan (Delhi), 2-Public Services International, 3-Public Health Resource Network, 4-World Health Organisation)
Email corresponding author: richachintan7838@gmail.com

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Abstract

The Covid-19 pandemic exposed various weaknesses in the Indian healthcare sector. It especially laid bare the challenges faced by front-line health workers, such as nurses. This paper encapsulates the findings from a study on employment and working conditions of nurses in private hospitals in the city of Delhi to describe the challenges they face with respect to unionisation, collective bargaining and other forms of social dialogue. It ends with policy recommendations with regard to these issues.

This study sheds light on the gaps between the governance and regulatory structures and their implementation, and highlights the role of social dialogue and union action in these processes. The focus on the role of collective bargaining and other forms of social dialogue during the Covid-19 pandemic; and difficulties faced by the nursing workforce in working through the existing regulation and governance mechanisms. The research questions that the paper attempts to answer are –

- ✓ What were the governance and regulatory regimes that affect social dialogue in nursing in the private healthcare sector in New Delhi, India;
- ✓ How does this environment shape the nature of social dialogue and collective bargaining during the Covid-19 pandemic

The main findings of the study are -

- Informal employment conditions and poor implementation of existing governance and regulations contributed to the deterioration of working conditions during the Covid-19 pandemic, including low salary, insecure jobs, lack of access to social benefits, high work-loads, poor occupational safety, insulting behaviour and harassment.
- There is reluctance and resistance of private hospitals to abide by court and government orders and lack of political will to enforce these orders.
- Unionisation among nurses has had positive impacts, giving them the confidence to approach management for social dialogue. Sustained efforts of associations and unions led to a petition in

the Supreme Court of India in 2011 and the landmark judgment in 2016 to legislate salary and working conditions and ensure parity among private sector and public sector nurses.

- Hospital managements perceive unions as a threat, and actively discourage formation of unions, by systematic victimization of those who attempt to organize nurses for their rights; and reluctance to hire male nurses, who are seen as being more active in organizing unions.
- A more confrontational nature of social dialogue creates an additional barrier to women's role in the nurses' organisations, in a profession they largely dominate.

Keywords: Nurses, Working conditions, Healthcare workers, Unionisation, Social Dialogue

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1. Introduction

As in most countries, in India too, the Covid-19 pandemic severely strained the health systems; while on the one hand it exposed the systemic weaknesses in the public health system, on the other it brought out the profiteering nature of the private sector.

It also laid bare the challenges faced by front-line health workers, such as nurses. In effect, the Covid-19 pandemic added to or exacerbated the pre-existing challenges faced by the nursing professionals. There were instances of loss of jobs, lack of PPE, non-payment of salary, increased workload, stress and harassment; much of which are common problems of nurses.

Nurses and midwives form the backbone of health systems across the world and constitute the largest occupational group in the healthcare sector accounting for almost 59% of the health professions. However, nurses, in many countries including India, face professional and social discrimination, gender bias, lack representation and leadership in policy making, and there is inadequate to poor regulation of their employment and working conditions. Since February 2020 the Covid-19 pandemic has exacerbated these problems and given rise to new challenges for them at their workplace.

Although trend of collectivisation among the nurse community in India can be observed to have picked momentum since the turn of the century, the recent period during the pandemic also saw strong action by the unions and associations. This paper encapsulates the findings from a study on employment and working conditions of nurses in private hospitals in the city of Delhi to describe the challenges they face with respect to unionisation, collective bargaining and other forms of social dialogue. It ends with policy recommendations with regard to these issues.

Research question(s)

The particular research questions that the paper tries to probe into are as follows -

- What are the governance and regulatory regimes that affect social dialogue in nursing in the private healthcare sector in New Delhi, India;

- How does this environment shape the nature of social dialogue and collective bargaining during the Covid-19 pandemic

This study sheds light on the gaps between the governance and regulatory structures and their implementation, and highlights the role of social dialogue and union action in these processes. Its unique contribution is the explicit attention to the role of collective bargaining and other forms of

social dialogue during the Covid-19 pandemic; and difficulties faced by the nursing workforce in working through the existing regulation and governance mechanisms.

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 with nurses and key informants as described below.

Respondents

1. Nurses from private hospitals in Delhi purposively 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. With a total of 16 hospitals, there were four hospitals each in the size categories: less than 50 beds, 51-100 bedded, 101-200 bedded and above 200 bedded. 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 5 years' work experience.

2. Hospital managers/administrators of above hospitals (4 approx.)

3. Representatives/office-bearers of nursing organisations, such as unions and associations (4 approx.)

4. Representatives/office-bearers of hospital owners' association (2 approx.)

Total number of respondents: 40 (32 nurses + around10 others as mentioned above)

Semi-structured interviews were conducted in English or Hindi, using a schedule of open-ended questions covering topics such as process of recruitment, salary and other employment benefits; provisions for safety at work, availability of leave, problems faced at work and grievance redressal mechanisms, and forms of collectivization.

An Information Sheet and Informed Consent Form respectively were shared with respondents. The interviews were audio-recorded after informing the respondents and taking their consent, and were subsequently coded and analysed thematically using the NVivo software. The FGD was conducted at a hospital site. Interviews were conducted in-person, online and telephonic modes.

3. Review of Literature and Context Setting

The nursing community faces poor working conditions and discrimination on a number of counts and is thus rendered vulnerable and insecure. Over the past decades nurses have begun to act collectively to fight for better employment and work conditions, leading to formation of various nursing association and unions such as in Kerala, Delhi, Mumbai, such as Indian Professional Nurses

Association (IPNA), United Nurses Association (UNA), Delhi Professional Nurses Association (DPNA). These had to organize protest marches, petitions demanding nurses' rights as employees and strikes (Roy, 2018; Nair & Healey, 2006), including issues faced by nurses in the private sector.

In April 2018, a strike by 370 nurses, organized by the United Nurses Association, at Maharaja Agrasen Hospital in Delhi was successful in getting better pay for the nurses, along with better work conditions and nurse to patient ratios (PSI 2018). In November 2018, over 350 nurses at Batra Hospital went on strike to demand better working conditions as per the National Accreditation Board for Hospitals and Healthcare Providers (NABH) norms such as maintaining of nurse-patient ratio; minimum wages as per Supreme Court recommendation; implementation of the maternity leave policy; curb on sexual discrimination; ESI coverage, and annual increments and bonuses (DNA Correspondent 2018). In 2017-18 nurses of private hospitals in Kerala too launched a prolonged struggle for basic demands such as wages of Rs 11,500, proper 8-hour shifts (PSI 2018).

In her 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: the salary then for a fresh nurse in a government hospital was in the basic pay scale of Rs 5500, whereas the total salary in a private hospital then ranged between Rs 2500 to Rs 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 also points to some of the challenges for nursing in collective organizing for their rights; such as: nursing being seen as an essential service that constrains collective actions such as strikes; the gendered nature of the work and pre-dominance of women in the profession; negligent attitude towards nurses' problems by traditional trade unions; growing hierarchy within nursing education - a by-product of professionalization – which is creating divisions among nurses and preventing collective action; nurses themselves not organizing for their rights but preferring options such as migration.

Biju (2013) in his discussion of the formation of politically independent unions by private hospital nurses in Kerala and their successful strikes in 2012, views these developments as a sign of class-formation and of 'politically ignored' labour unrest in the hospital industry, and discusses the emergence of nurses' organizations such as UNA, IPNA, the United Nurses Association, Indian Professional Nurses Association, role 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 narrative of nursing as a noble service, and the recruitment of large numbers of male nurses who

initiated the 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 the agitations, and 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.

Below we present a situation analysis of the nursing profession, working conditions of the nurses, the disparities in wages and the various forms of discrimination they face. These are the conditions to be overcome, for which unionisation and collective bargaining have become important and necessary. We also discuss the role played by associations and unions, especially during the pandemic.

3.1 Size, composition, distribution

Till date reliable, comprehensive, updated data on the health workforce, including that on nursing workforce, remains weak in India, due to factors such as multiple sources providing estimates using non-comparable methods for data collection, or professional registries such as those of Indian Nursing Council (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 (IndiaSpend 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 in the country was reported; India had only 1.7 nurses per 1,000 population (includes nurses, midwives, women health visitors and auxiliary nurse midwives) as against the WHO recommendation of 3 nurses per 1000 population (WHO 2010).

The shortage of nurses is not simply a matter of absolute numbers, but 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, international migration due to factors such as low salary-poor working conditions- low status and professional social discrimination (Gill 2016).

3.2 Low Professional status, professional and social discrimination

Studies have examined the prevalence of professional hierarchies in the healthcare 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 on nurses and midwives, and the lack of nurses in administrative and policy-making processes, even those that directly affect nursing profession. 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 putting them in disadvantaged position but in varying degree. 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 the 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).

3.3 Work conditions – wages, occupational safety and health, contractualisation

The low professional status of nursing along with the gender-caste composition of the nursing workforce has consequences for the working conditions of nurses. In 1989 a High Power Committee on Nursing and Nursing Profession of the government mentioned problems of long working hours, inadequate work place (duty stations), lack of supplies and equipment, forced performance of non-nursing duties among the problems faced the nursing personnel 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. The Jagdish Prasad (JP) committee appointed by the government in 2016 observed that adequate salary and basic facilities were not being provided to nurses in private hospitals and conditions of nurses in these hospitals are pathetic. It recommended that steps need to be taken to uplift the standards and put them at par with government employed nurses, as well as to formulate appropriate legislation to improve the working conditions in private hospitals

Employment on contract for 1-2 years, renewable at the end of the period (fixed term contracts) is the major feature of working conditions in private hospitals sector (Basu 2016). However, in the public sector too, while permanent nursing staff may have better conditions of employment, there is a gradual move towards contractualisation and dilution of their existing entitlements leading to gradual shift even in work culture of the public hospitals (Roy, 2018).

Wage Bills, Revenues and Profits of private hospitals

Wide variations in the wages of nurses across different types of hospitals have been reported, with nurses in private health sector paid significantly less than similarly qualified nurses working in public health facilities (Seth 2017, Walton-Roberts et al 2017), and sections of nurses not getting even minimum wages (Nair 2010). Nurses in the private sector struggled with low incomes that were not adequate to support a decent life, work stress, and commuting challenges, which together led to a poor work life balance (Taware and Patil 2018).

An analysis of the wage bills, revenues and expenditures of six major corporate hospitals in 2018-19 (Apollo Hospitals, Fortis Healthcare, Max Hospitals, Healthcare Global HCG, Narayana Hrudayalaya NH and Shalby Hospitals) showed that the average revenue (earnings) of the six hospitals in 2018-19 was ₹27,282 million, of which around 88 % (₹24,219 million) went on costs incurred. Most of the hospitals spent 17-18% of their earnings on paying doctors with Apollo spending nearly 28%; whereas 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 I.2 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

Source: Soni (2019)

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 healthcare expenditure by more than Rs 35,000 crore and Rs 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). Yet private hospitals argue that they do not make as much profits and are reluctant to pay decent wages to nurses.

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 pre-dominantly by women and also *mostly as a temporary or transit job to a better one.*

3.4 Regulation of employment and working conditions of nurses

The ILO instruments that set the standards for employment and working conditions in nursing in both public and private sector are the Nursing Personnel Convention 149 (International Labour Organization, 1977) and Nursing Personnel Recommendation 157 (International Labour Organization, 1977). The ILO initiated a General Survey process in 2020 towards possible review of these instruments. While Convention 149 is short and sparse, Recommendation 157 contains noteworthy principles, such as a fair remuneration commensurate with duties and responsibilities, no discrimination between working conditions in public and private sector, including 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 has an extensive set of labour laws that cover most aspects of workers' rights in their workplace, with their employer and in relation to unionisation. 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 Labour Codes, respectively: the Code on Wages 2019, the Code on Industrial Relations 2020, the Code on Social Security 2020, and the Code on Occupational Safety, Health and Working Conditions 2020[1]. 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,

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

regulate the rights of nurses in the private health sector in Delhi with regard to their employment and work conditions. The minimum wages in Delhi in 2019 for clerical and supervisory staff was: Rs 16,341 per month for those who are not matriculate; Rs 17,991 for those without graduate degrees; and Rs 19,572 for those with graduate degree or above[2], so paying a nurse below this would amount to violation of the minimum wage law.

Nurses in the private sector are also entitled to social protection such as health insurance or the Employees' State Insurance (ESI) - for nurses with a salary of up to INR 21,000 per month; Provident Fund (PF) for pension; maternity benefits; as well as gratuity at the time of leaving a company - in facilities with at least 10 employees, and for nurses employed for not less than 5 years; and annual bonus - in facilities with at least 20 employees, and for nurses with a salary of up to INR 21,000[3], among other benefits. Nurses continue to be covered under the new labour codes as they are not explicitly excluded. It is the thresholds, ceilings and other specifics of the laws that might create exclusions.

The literature also points to a form of bonded labour that was practiced by private nursing colleges, especially those with attached medical colleges or hospitals, as well as other private hospitals: they would retain the certificates of fresh nurse graduates or recruits as a guarantee that they would not leave for a certain period; if they wished to leave, they would have to pay a fixed amount of Rs 2-3 lakhs to get back their certificates (Debroy 2012; Harigovind 2011; DNA Correspondent 2011; Shelar 2011).

In a Public Interest Litigation (PIL) filed in 2011 in the Delhi High Court by a nurse challenging the withholding of her certificates by Indraprastha Apollo Hospital, Delhi, the court issued notices to Apollo Hospital and the Law Ministry, saying that this was tantamount to making the nurse a slave, that nurses should not feel bonded, and directed the Delhi Health Ministry to frame guidelines to protect the interests of nurses. The Indian Nursing Council subsequently issued a circular in August 2011 prohibiting this practice of 'bonded labour' by nursing educational institutions (Indian Nursing Council, 2011).

Following the suicide by a nurse working in a hospital in Mumbai in August 2011 (Staff Reporter 2011), the Trained Nurses Association of India (TNAI) filed a petition in the Supreme Court of India (SC) on the abysmal wages and working conditions, and this bond system prevalent in the private healthcare sector across the country. In 2016 the judgment in this case by the SC, observed that the

2 Government of National Capital Territory of Delhi 2019. Delhi Gazette, 22nd October, Labour Department. N.C.T.D. No. 257

3 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

nurses who are working in private hospitals and nursing homes are not being treated fairly in the matter of their service conditions and pay, and ordered that the Central government must do the needful for improvement of working conditions and pay of the nurses working in private hospitals and nursing homes, which can ultimately be given a form of legislation by the States or by the Central Government itself. The SC directed 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 testified that the bond system had now been abolished, and hence that grievance did not survive.

The Jagdish Prasad(JP) Committee, appointed in February 2016 by the Ministry of Health and Family Welfare in compliance with the above order of the SC, made the following recommendations:

- In hospitals with more than 200 beds, salaries of nurses should be at par with that in State Govt. facilities for the corresponding grade. For facilities with more than 100 beds, salary should not be more than 10% less in comparison to State Govt. facilities. For hospitals with more than 50 beds, salaries should not be more than 25% less compared to State Govt. facilities. Salary given to private nurses should not be less than INR 20,000 in any case even for hospitals with less than 50 beds, which is more than INR 2000 above the current minimum wage that applies to private sector nurses.

- Working conditions such as leaves, working hours, medical facilities, transportation, accommodation, should be at par the benefits granted in State Govt. 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 JP Committee. In a challenge to this order by private hospital owners through Association of Healthcare Providers of India (AHPI), the Delhi High Court upheld this order. However, no action has been taken against hospitals violating the order.

Despite the importance of the nursing workforce for the healthcare 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.

4. Findings

Evidence shows that while nurses face a range of harassment, challenges and problems at work, low salary/remuneration is a major problem – whether it be in big corporate hospitals or the non-corporate

big and small hospitals and nursing homes. A combination of policies, changes in gender composition of nursing, and historical attitudes and practices have kept salaries low in the private healthcare sector. Over the past decade, various nursing associations have tried to deal with the issues.

Informal employment conditions and poor implementation of existing governance and regulations contributed to the deterioration of working conditions during the Covid-19 pandemic, including low salary, job insecurity, lack of access to social benefits, high work-loads, poor occupational safety, insulting behaviour and harassment.

4.1 Collective action translated to legal steps and more

Around 2010 there were strikes and agitations by nurses in the three metro cities of Calcutta, Bombay, and Delhi, as described by some office-bearers in our study and discussed in literature. A spontaneous but strong *nursing movement emerged for the first time, mainly, nurses from Kerala started getting organized.* Out of these spontaneous movement emerged organised structures of collectivisation, such as Indian Professional Nurses Association (IPNA), Delhi Private Nurses Association (DPNA), 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 regarding its response to the issues raised by nurses. The government had to state its commitment to improving the working conditions of nurses.

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. In December 2011, TNAI filed a civil writ petition (WP) in the Supreme Court (SC) of India 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.

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 asserted 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*', and framed the problems of the nurses as an issue of public health and public welfare. The SC

admitted the petition by TNAI as an issue of importance to the health of the people. Five years later, the case was disposed of by the SC in January 2016 with a written Order which 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',* and directed the government to form a committee to look into grievances raised in the petition.

This was seen as a historic development by nursing organisations, on the matter of remuneration of nurses. In compliance with this SC Order, in February 2016, the Ministry of H & FW appointed the JP Committee to look into the grievances of nurses and provide recommendations to improve the situation of nurses with regard to their working conditions and remuneration. The response of private hospital owners to these developments was that implementation of the JP Committee recommendations would result in massive economic impacts.

Actions by governments at the State level on the matter seem to have been taken under pressure from nurses' organisations, as was for instance seen in Kerala (PSI 2018). In the face of the lack of proactive steps by Delhi government, the IPNA filed a writ petition in 2017 in Delhi High Court (HC) seeking directions regarding compliance with above SC order. 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.

The private hospitals, through AHPI, filed a writ petition in Delhi HC in 2018, for quashing of this order of the Delhi government claiming implementation of the recommendations was not financially viable and that public and private pay-scales cannot be equated, as it overlooks the fundamental differences between the two categories of nurses.

An 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. 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 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 10th 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.

4.2 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, and applied to private hospitals and nursing homes, such as Wages Act, Labour Act and Clinical Establishment (Registration and Regulation) Act, 2010 etc. 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 rampant violation of the existing general and non-specific labour laws, in consonance with earlier findings and government reports. The recommendations of the JP Committee are not fully implemented. There is reluctance and resistance of private hospitals to abide by court and government orders and lack of political will to enforce these orders that would ensure decent work conditions for nurses in private healthcare.

In addition, labour lawyers contend 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.

According to Advocate Ramapriya Gopalakrishnan "*The existing legal framework does not adequately protect the labor rights of nurses. There is therefore a need to frame a separate sector specific legislation to protect the labor 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*". 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.

Nurses' organizations feel that they there is lack of political will. In their opinion the delay is happening because of issues of collusion and political-industrial nexus: '*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?" Many hospitals are in fact run by the MP, MLA those who are legislators, and in the executive also they are so influential.*

4.3 Collectivized Action and Social Dialogue

4.3.1 Unionisation at the hospital level and barriers to the same

The interviews brought out the fact that the presence of an organisation of nurses and that of its representative in the hospital gave confidence to some nurses to seek relief from the harassment that they faced, especially female nurses.

The lack of presence of an organisation of nurses was highlighted as a setback in making nurses' voices heard. Respondents expressed 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. However, respondents also expressed that a collective voice might not be enough and nurses are sometimes required to undertake collective action for their situation to improve, including mass leave or strike actions, for more systemic change at the workplace. During the Covid-19 pandemic, it was only after protests and approaching the court that facilities like PPE, drinking water in covid wards etc. were provided.

Hospitals discourage collectivized relations by resisting employing male nurses. Other practices were also adopted to discourage or prevent nurses from forming associations and unions, which included pressure through group in-charge, k*eeping a watch, increasing the workload, etc.* The commonest practice against those who organize nurses to take up the problems with the management and initiate union activities are a) to dismiss them; b) refusing to give experience certificates at the time of leaving or mentioning that they participated in y protest action; 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 resign; e) frequent transfers; f) paying different salaries to staff recruited at the same time, in same area, and thus creating rift;

Apart from such employer practices to deter unionization, other challenges to collectivization were related to factors such as the social constructs. It was pointed out that as the females are mostly burdened with the household chores, after the duty they are busy with their family. Sparing time for association work was a problem. In addition, 'they do not get any permission from their families, they were afraid to comment on anything; so they do not participate actively in any issues in the hospital also.

4.3.2 Elusive social dialogue

Social dialogue[4] is can exist as a tripartite process, with the government as an official party to the dialogue, or as bipartite relations only between labour and management (or trade unions and employers' organizations), with or without indirect government involvement. The main goal of social

[4]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.

dialogue itself is to promote consensus building and democratic involvement among the main stakeholders in the world of work.

The 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 conditions (ILO, n.d.). The fundamental rights of freedom of association and collective bargaining need to be respected and spaces for social dialogue kept open. Unionized nurses have more 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.

The study findings point to a ground reality where social dialogue and collectivization are very challenging for nurses. 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. On the other hand, respondents also expressed that nurses' organisations have to force hospital management to enter into negotiations by resorting to industrial actions and involve the labour conciliation machinery.

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. It is a worrying trend that even if collective action brings an improvement to the collective, a few individuals still have to pay the price personally.

From what respondents shared, they have to face an inimical environment in which forming a nursing organisation has to be hidden, until the organisation is strong enough to withstand the management's backlash. 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.

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. Our findings point to a complete lack of bi-partite bargained agreements that are outcomes of collective bargaining processes entered in by both parties voluntarily. This points to a systematic violation of the effective recognition of the right to collective bargaining, which is part of ILO's core principles.

The findings with regard to both unionisation and social dialogue point to a systematic violation of the international principle of freedom of association and effective recognition of the right to collective bargaining, enshrined in two ILO Fundamental Conventions, namely Convention 87 on Freedom of

Association and Protection of the Right to Organise, and Convention 98 on the Right to Organise and Collective Bargaining[5]. Our findings also show that the systematic violation of these rights impact disproportionately on women's participation and contribute to the lack of women's leadership in nurses' organisations in the private sector.

Our study indicates that unionisation among nurses has had positive impacts, giving them the confidence to approach management for social dialogue. It was the sustained efforts by nurses themselves, through associations and unions that led to a petition in the Supreme Court of India in 2011 on working conditions and practice of withholding certificates as a bond, and the landmark judgment in 2016 to legislate salary and working conditions and ensure parity among private sector and public sector nurses.

However, hospital managements perceive unions as a threat, and actively discourage formation of unions, by systematic victimization of those who attempt to organize nurses for their rights; and reluctance to hire male nurses, who are seen as being more active in organizing unions. The latter are often forced to resort to industrial action to achieve bi-partite negotiations and ensure that their issues are heard and resolved.

A more confrontational nature of social dialogue creates an additional barrier to women's role in the nurses' organisations, in a profession they largely dominate.

5. Conclusion and Recommendations

In summary, the existing environment of inadequate regulations and weak implementation and monitoring systems, 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 context of Delhi, some specific recommendations that emerge from the study are as follows:

1. The central and state governments, including the Delhi Government, must immediately and strictly implement the JP Committee recommendations, for parity of private hospital nurses with those in the public sector, and initiate steps towards enacting legislation to specifically regulate salary and other working conditions of nurses in the private sector. The Delhi State government must immediately and strictly implement its order of 2018, directing all hospitals and nursing homes to comply with the recommendations of the JP Committee.

2. An independent oversight mechanism needs to be set up to ensure and monitor progress on the implementation of the JP Committee recommendations and steps towards enacting state-

[5]Under the ILO Committee on Freedom of Association, complaints on the violation of the freedom of association can be brought by workers organizations against governments even if they have not ratified the said conventions.

level legislation. While enacting the nurse-specific legislation Delhi and other state governments need to subscribe to the recommendations laid down in the Decent Work Agenda of the ILO upheld by WHO for healthcare workers, the ILO Nursing Convention 149 and Nursing Personnel Recommendation 157.

3. Inspection of private health facilities for compliance of private hospitals with existing labour laws and new nurses-specific legislation that will be enacted needs to be ensured, in line with the ILO Labour Inspection Convention 81. Budgetary allocation to the labour adjudication and inspection system is required in order to improve monitoring and compliance. Accreditation should not be treated as a substitute for these statutory mechanisms.

4. Unionization of health workers must be permitted as a matter of right and any discouragement needs to be curtailed proactively through the inspection and monitoring mechanisms to be set up as in Recommendations 2. A unionized health workforce not only leads to a higher patient safety, better conditions for workers in healthcare 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.

5. Considering that nurses are a permanent requirement for the running of any hospital, nurses must be part of the regular workforce and employed on permanent terms by the institution where they work.

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