Book Review

Who Cares for the Carers?

Dhruv Mankad
Managing Trustee, Anusandhan Trust, Mumbai

Who Cares? Socio-Economic Conditions of Nurses in Mumbai
Aarti Prasad
Himalayan Publishing House
2014, pp. 253; Rs. 458/-

"Nursing is a practice discipline and it is a political act." - Canadian Nurses Association

One of the key problems with India's healthcare system is an acute shortage of health workers, including nurses. India had one nurse per 1,264 of the population in 2004 and 1.3 nurses per one doctor (Govt. of India 2005) as against recommendations by a High Level Expert Group (Planning Commission of India 2011), which proposed one nurse per 500 persons and three nurses per doctor. The second, and an equally important problem, is human resources for health policy in the public and private sector. Absence of human resource recruitment, retention, training, management and social security policies and practices, physically and mentally drains the workforce, which is already in great shortage. Inter-state, intra-state and international migration is one of the results of this.

Nursing as a profession is highly women-dominated, without engendered policy in its budgeting, work placement and practices (Chakraborty 2013). 80% of nurses are employed in urban settings, mainly in the private sector. The book under review, *Who Cares? Socio Economic Conditions of Nurses in Mumbai,* focuses on the socio-economic profile and working conditions of nurses employed in the public and private sector in Mumbai, with a gender perspective.

Aarti Prasad explores the linkages between health and development: health results in increasing productivity which leads to poverty reduction, and an increase in accessing health care services

leads to higher capability of the workforce. She also covers the history and the process of engendering the nursing profession, and the trends during the planning phase, including the period of globalization, in India. The book is based on her doctoral study conducted in Mumbai.

Some of the key findings of the study conducted in municipal and private hospitals as well as nursing homes in two wards of the Mumbai Municipal Corporation are:

1. There is a predominance of nurses from the age group of 17-35 years, most of whom are women.
2. Christian nurses from Kerala are predominant in private hospitals and Hindu nurses from Maharashtra in municipal hospitals.
3. Parents of unmarried nurses, mostly of 17-24 years of age, were less qualified than the spouses of married nurses.
4. Most of the nurses employed in nursing homes and several employed in private hospitals were not qualified nurses and therefore not registered in nursing councils. They were also not members of the union.
5. Poor working conditions and a heavy workload were the main causes of attrition:
    a. While most nurses employed at municipal hospitals were 'confirmed', many working in private hospital or nursing home were employed on an 'ad hoc' basis.
    b. Remuneration for those at municipal hospitals was higher than that of those at private hospitals, and was as low as Rs. 1000 per month in a nursing home.
    c. Increments and the provision of allowances like HRA were consistent in the case of municipal hospitals, and were mostly absent for nurses working in private hospitals.
    d. Other facilities and services such as food allowances, uniform allowances, medical services, and interest-free loans were inconsistent.
    e. Provisions for leave were available for confirmed staff, but difficult for those not yet confirmed, particularly in private hospitals. Light duties were available for pregnant women in both municipal and private hospitals.

f. Restrooms, crèches and transport facilities were not available in any hospital, nor were any entertainment facilities.
g. Except for large private hospitals, there was no induction process in place for nurses. However, advanced training and computer training was available in these hospitals, and in some municipal corporation hospitals.
h. Grievance redressal systems seem to be lacking, particularly in municipal hospitals, and issue-specific in private hospitals.

Prasad has rightly recommended that all of the gaps identified by her study must be filled—which includes improved budget allocation for nursing education, improved regulation of nursing education for nurses employed in private nursing homes, and better working conditions both in municipal hospitals and private hospitals–including remuneration, allowances, workload, social security, welfare measures etc. An important recommendation is the uniform application of rules and availability of facilities in all municipal hospitals in the city, and not just applying these to specific hospitals. Another important recommendation is greater participation of nurses in decision-making.

Aarti Prasad has pointed out key areas which affect the health of the nurses themselves; who are supposed to take care of the ill and the aged. Surprisingly, what the book revealed was that even municipal corporation hospitals, although better in terms of working conditions, are not able to cope with the crisis of nurses due to the overall shortage of nursing staff coupled with a heavy workload. This situation is detrimental to the welfare of its employees; and employee welfare should be a major goal of a healthcare system run on the bases of public taxes. Cost-cutting, under-costing the value of an important service-providing segment by recruiting less than the number of required staff, employing non-qualified staff, and long working hours; comprise a routine path of profit-making for private hospitals, as Prasad's study points out.

This situation generates a low quality of services (not necessarily due to the nurses' performances, as the study proves through records of the various complaints against nurses) at a low cost to the patients; with higher remuneration for nurses in municipal corporation hospitals

simply due to being overburdened with patients. This situation can be improved simply by increasing the number of nurses and hospitals.

In private hospitals, high quality performance of nurses can be linked to higher remuneration, as in absence of this the growth in the hospital performance and the return in investment is jeopardized. In a market economy, it is clearly seen that cutting cost of quality of service in fact reduces the return particularly in health care. A white paper by Washington State Nurses Association states,

> "Over the past three decades, much of the focus on nursing's economic value has centred on issues of adequate staffing, particularly in hospitals. These issues came into focus in 1983, following the implementation of the Medicare inpatient Prospective Payment System (IPPS). Many hospitals initially responded by reducing their RN staffing. This situation reversed itself in fairly short order, however, as hospitals found that shorter hospital stays—the key to financial health under IPPS—required a greater intensity of RN services. (Keepnews 2013)

It also recommends that nursing organizations should:

- Continue efforts to identify and define the economic value of nursing. They should disseminate relevant research findings and conduct initiatives to educate nurses about nursing's economic value. However, these initiatives should present the economic value of nursing within the broader context of nursing's social and economic value.
- Target their messages on nursing's economic value based on distinctions in the economic, business, scientific and political cases for nursing care quality. (Keepnews 2013)

Considering these recommendations alongside those presented by Prasad, one clearly sees that there is a contradiction between the welfare mindset and the realities of market economics. In an

era of globalization and liberalization of economy, advocacy strategy has to be realigned at three levels:

1. Advocacy at the government level:
    a. For nurses employed in municipal hospitals, improved implementation of the rights and welfare of the nurses as employees.
    b. For nurses employed in private hospitals, legal provisions for occupational safety, regulation of their training along with punitive action on hospitals not complying with implementation of their rights.
2. Advocacy at private hospitals: Regulation and monitoring of the quality of services with short stay as an indicator and quality of services to the nurses as a way of increasing their "economic value."
3. Advocacy at the level of nurses themselves: 'Organize, Educate and Agitate'—whether 'confirmed' or ad-hoc, highly qualified or untrained, in municipal hospitals, private hospitals or nursing homes—for their rights as health workers and as women.

In a nutshell, Aarti Prasad has undertaken a comprehensive study of the working conditions of nurses, and presented her findings through a gender-based economics perspective with emphasis on social implications. It can generate further discourse and critical thinking from a political and economic viewpoint, considering the political and economic value of nursing in healthcare.

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