Health workers' Rights in the Time of COVID-19

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As of 21 April, the COVID-19 pandemic has infected about 2,482,158 people worldwide and contributed to 170,470 deaths. In India as on 20 April, the number of people infected with COVID-19 is 17,656 with 559 deaths. The corona virus Sars-CoV-2 that causes COVID-19 is potent and can spread easily and at a fast pace.

A large, sudden influx of patients can put extreme stress on both the healthcare system and on its health workers, as we are currently witnessing in many countries in Europe and the United States. Health workers are generally at high risk. In Italy for instance, it has been reported a staggeringly high proportion of all those infected are healthcare workers. India is witnessing an increasing number of cases of infection among health workers.

The situation is made worse by the fact that COVID-19 has hit India against the backdrop of a neoliberal assault on healthcare. This assault has meant that public health facilities are in disrepair, neglected, and overburdened. At the same time, private hospitals and nursing homes have proliferated, without adequate regulation.

The current situation is dire. Testing is inadequate, there is severe scarcity of test kits and the much-publicized antibody-based kits have barely begun trickling in, more ventilators are needed, and the availability of personal protective equipment (PPE) is poor and uneven across regions and hospitals.

In such a situation, health facilities themselves can become sources of spread of infection, with three concentric circles of risk: individual health workers in direct contact with patients; other employees including fellow-nurses, doctors, and other health workers; and three, the public coming to a hospital. Recent episodes, such as in Delhi, Mumbai, and Hyderabad have shown that this can occur at any health facility, not just at COVID-19-identified ones, particularly given that the current Indian testing and patient management protocol has no provision for testing symptomatic patients without a contact history and isolating those who are positive but asymptomatic. These patients might have high infectivity and will be coming into close contact with many healthcare providers without either patient or health providers knowing.

Health workers at the community level, such as ASHAs, who are deployed either for Covid-19 outreach and community awareness or for routine community level work such as immunisation, are also facing higher risk of exposure to the virus. Hence, the rights and protection against risk of health workers on the one hand, and the robustness of the health system on the other, and the policies with regard to testing, all deeply intersect in the times of COVID-19.

As the health workers are on the frontlines of our response to COVID-19, they face higher risks of infection, overwork, and stress. Hence, any strategy to fight the pandemic should consider the rights and protection of health workers, including through provision of adequate PPE, access to testing and treatment, proper training, covering them for COVID-19-related sick leave, quarantine and provided compensation, allowed to opt out of performing their work in risky conditions, without risk of losing their jobs, actively involving their representatives in setting up safeguard measures in health facilities, organising work such as to minimise their risk to exposure, payment of legal wages and overtime without any mandatory or so-called voluntary cuts, adequate facilities such as accommodation,

transportation, child care, and nutritious meals, protecting them against stigma, violence, discrimination, and sexual harassment.

The related, broader issues of health workers' employment, equal pay for equal work, and rights to occupational health and safety and better working conditions is central for countries to be able to cope with COVID-19 now.

Precarious health workforce makes the health system more fragile

The continuous underfunding of public healthcare has meant that in public hospitals, due to budgetary tightening, vacancies of health professionals from doctors, to nurses to paramedics have not been filled. This imposes a heavy workload on the existing staff that was already hard for them to manage.

In many facilities, professional staff shortages have been dealt with by hiring on short-term contracts or deploying field staff in hospital settings, such as with ANMs. Health workers who are 'non-professionals', such as ward attendants and housekeeping staff, cleaning and security staff are most often hired through contractors, at low wages, pathetic working conditions, and too often in violation of the labour law.

While the private health sector has thrived and expanded, its workforce is highly underpaid, except for high profile and specialised doctors. Nurses in private hospitals are, at best, paid around the minimum wage for a skilled worker, and most often below this legal bench mark. This sets the scale for other staff, who also face the challenge of being hired through a third party which makes their tenure highly insecure and without social security coverage

The workforce at the primary level of care provided in health posts and at the community level are unarguably the most neglected. Field/community health workers are denied the status of a worker by the State, and thus denied minimum wage and any other rights of a worker under the law. Informal employment leads to unclear responsibilities towards workers, and has created blind spots in the system. ASHAs and CHVs have been deployed for case identification without adequate safeguards. Sanitation and support staff who are contractual are being preferentially deployed as compared to regular staff, so as to avoid social security obligations in case of their illness.

The precariousness faced by the vast majority of the close to 40 lakh health workers has to be addressed as a matter of priority as part of health system preparedness that the lockdown is meant to enable.

Previous outbreaks of highly infectious communicable diseases have demonstrated that public health outcomes are significantly improved when labour rights are respected, and trade unions are able to effectively represent workers actually exposed and potentially exposed to the disease. The active involvement of health workers' representatives in government decision-making is necessary to safeguard workplace safety and health and ensure the cost of the crisis is not borne by healthcare personnel.

In summary, our demands are as follows:

SPECIFIC

1. The Government should provide adequate Personal Protective Equipment. Government should also provide updated guidelines regarding the rational use of PPE that also cover non-COVID-19 facilities, facilitate the production and logistics of distribution, increase PPE procurement orders to ensure adequate access to all health workers, and if required, intervene in the market to ensure that PPEs are sent to the districts/regions where they are urgently needed.

2. The government should ensure that guidelines regarding the use of PPE are strictly followed in both public and private settings, and that there is no discrimination against workers on the basis of

hierarchy, employment status, or other reasons. A monitoring mechanism should be put in place in order to enforce strict adherence to PPE guidelines in public and private settings.

3. The government should ensure comprehensive health care free of cost to all health workers, including outpatient, hospitalisation, and regular testing, with special attention to informal health workers. Special provision of regular testing needs to be ensured for health workers performing high risk tasks, even if asymptomatic.

4. The government life insurance scheme should cover all health workers including in private settings and the estimate of health workers needs to be modified to reflect the real size of the health workforce in order to avoid denial of compensation in the future.

5. Special paid leave in case of COVID-19-related sickness and quarantine should be provided, including to workers on short-term contracts and employed through a third party. A special compensation should also be announced for health workers who contract COVID-19 as an occupational disease. Extra hours should be regulated and remunerated as per the law.

6. Health workers who are pregnant, lactating or have co-morbidities should not be put on duty in the COVID-19 ward. They should be assigned appropriate tasks within their profession that does not expose them to the risk of COVID-19.

7. As health workers undergo considerable stress during emergencies such as the one we are facing, counselling and mental health support should be made available to them. Breaks and time-off should be maintained. Further, health workers' right to opt out of work when they are not provided with a safe working environment and adequate protective equipment should be respected.

8. The government should facilitate appropriate training programmes and materials for the diverse categories of health workers and for the different levels of risk depending on the role of workers and the role of facilities.

9. Adequate arrangements need to be provided to health workers in high-risk environments, such as ICUs and isolation wards, including accommodation and separate restrooms.

10. The government should take appropriate steps to ensure a safe workplace and work environment, protect health workers from harassment by the police and the community, including a strong media campaign to counter stigma of all forms, and appropriate orders to outlaw stigma and discrimination. A grievance redressal mechanism should be put in place, including internal complaints committee in case of sexual harassment.

INSTITUTIONAL

11. Central and State governments should involve health worker unions in the process of information-sharing, training, and workers' safety. This will facilitate an effective outreach to all concerned health workers. Managements should facilitate an active role for health workers' representatives in determining safety measures and safeguards of their health.

13. The infection control component of the government's quality accreditation programmes must be implemented universally across states, including in the private sector, along with a monitoring mechanism by the government. In case private facilities fail to follow the government guidelines and resolve issues with regard to infection control and other safeguard measures, the state government should consider requisitioning the errant private facilities.

14. Management of health facilities should make adequate arrangements for health workers at the facility, including but not limited to options for crèche or child care, transport to the place of work, an official letter and an order to the local police and administration so that health workers are not

harassed by the police when travelling to work, regular provision of soap and sanitizer, and adequately nutritious food at the hospital or through other effective systems.

15. Health workers who are not able to work on a regular basis due to the lockdown or due to precautionary measures should be considered on duty and paid their full wages. All governments and private facilities should refrain from asking health workers to compulsorily or voluntarily forego their wages in full or partly. A health worker helpline linked to both the Ministry of Labour and Employment and the Ministry of Health and Family Welfare should be available for health workers to notify non-payment of wages and arrears.

16. State governments should ensure compliance with the Supreme Court recommendations relating to the long overdue increase of wages in private healthcare facilities. Relevant directions should be issued in this regard.

17. There should be a health worker helpline that is able to provide online or telephonic support to health workers in both public and private sector, and protect health workers role as whistle-blowers without putting their jobs at risk. This helpline should register complaints and grievances and be linked to competent authorities who would be responsible for taking timely action on these complaints.

18. The waiting list of the UPSC and the SSC should be used as a base to fill vacancies in health facilities under the central government. The waiting list of the equivalent board or commission under each state should be used to fill vacancies in facilities under the state governments. Health workers hired on a short-term contractual basis are a vulnerable workforce at increased risk of infection. This weakens the risk management process in the facility and puts the larger public at risk.

19. Central and state governments should/must increase their budgetary allocations for health in order to cover health workforce-related costs, such as filling up vacancies, regularization of informal workers including scheme health workers, payment of wages as per the law and payment of arrears. This increase should be incorporated into subsequent annual budgets. This will be of long-term benefit for strengthening the public health system in India, and so we can cope better when the next health crisis hits us.