



Illustration: Chuan Ming Ong

COMMENT

A Political Economy Analysis of the Impact of Covid-19 Pandemic on Health Workers

Making power and gender visible in the work of providing care

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Health and auxiliary workers are at the forefront of the COVID-19 pandemic response. They have been applauded as heroes by patients and politicians, but this has not translated into policies that address their rights and needs. Health workers face a double risk of infection, as they run the risk of contracting the virus in their workplaces, and in their communities and families (WHO 2020a). Even though a nominal consensus exists that health workers deserve protection, the lack of personal protective equipment (PPE) among health

workers has been a widespread problem, especially in the early phases of pandemic (The Lancet 2020).

This paper assesses the impact of the COVID-19 pandemic on the most vulnerable categories of health workers in different countries, locating them within the country's health system and political economy of healthcare. It focuses on the impact of precarious and contractual work, weakening of the public sector, privatization and commercialization of the health system on health workers, and differences between the global north and the global south, through an intersectional lens. Finally, it provides policy recommendations embedded within the framework of labour and socio-economic justice.

To underline the specific effects of inequalities and power relations among countries, social groups, and occupational groups, we focus on three categories of health workers who are situated at the lower levels of the hierarchy of health-related professions, namely nurses, community health workers (CHWs), and auxiliary workers. Auxiliary workers include laboratory and other technicians, workers involved in long-term care, sanitation workers, ward attendants, administrative, security, catering and cleaning staff, pharmacists, ambulance drivers, mortuary workers, carers providing homecare and home nursing, and many other categories of workers. Many of these workers are not commonly included in definitions of frontline health workers. This paper discusses the reasons for such exclusions and the need for them to be recognized as health workers.

Recent estimates show that at least 17,000 health workers have died from COVID-19 since the start of the pandemic.

Recent estimates show that at least 17,000 health workers have died from COVID-19 since the start of the pandemic (Amnesty International 2021). Others have experienced a huge surge in workload, adversely impacting their mental and physical wellbeing. In addition to these issues, health workers have also faced lack of social protection, loss of wages, and exposure to hostility and violence.

It would however be short-sighted to attribute all these problems solely to the pandemic. Most of the aforementioned changes experienced by health workers are linked to elements introduced in public services by neoliberal policies, pushed by international organizations such as the World Bank (Navarro 2007). By insisting that governments should limit expenditure on social protection mechanisms, including healthcare, the promoters of such policies have ensured that pre-existing social inequities become more pronounced, and impact the quality of life of most people in the world (Sell and Williams 2020).

Neoliberal policies impact healthcare in many significant ways – caps on public employment leading to staff shortages; salary cuts; increased privatization and commercialization of health services; de-standardization and informalization of work, including expansion of less regulated or “volunteer” workers, e.g., nurse aids and CHWs, became the rule of the day (PHM 2018). All these elements have contributed to a general worsening of working conditions in healthcare, and have had a particularly strong impact on workers, especially in the lower levels of the hierarchy of health-related professions. Therefore, the risks both during, and before the pandemic, were not equally distributed.

As we show below, workers in the private and public health sectors have faced different challenges. However, frontline health workers at the lower end of the occupational hierarchy – mortuary workers, sanitation workers, CHWs, and contractual workers, in both public and private sectors – have faced more problems than others. These workers often come from populations which are recognized as generally vulnerable due to their gender, caste, race, class, migration, ethnicity or other status. For example, globally the share of women in the health and social care workforce is as high as 70% but they are clustered in the lowest rungs of the health workers hierarchy (WHO 2019). While the structural drivers of inequality make them more vulnerable and push them into more precarious and exploitative work, the outcomes and conditions of their work become drivers of further inequalities.

Theoretical Framework: Making global and local power relations that determine the conditions of work for healthcare workers visible using the concept of ‘care extractivism’

Using the theoretical frameworks on employment relations, working conditions and health inequalities proposed by Benach & Muntaner (2013), we develop a theoretical framework to analyse the impact of the COVID-19 pandemic on health and auxiliary workers. We also draw on the concept of “care extractivism” as articulated by Wichterich (2020), as well as work of People’s Health Movement (PHM) on health inequities and social determinants of health (Baum et al 2009; Sanders 2019; Paremoer et al 2021). These analytical frameworks reveal the ground reality that health is not reducible to a biomedical condition, or simply the absence of illness, and that health outcomes are shaped by the structure of the political economy, labour market, and social relations. They show that securing health for all ultimately requires more than medical services; it also requires a ‘social vaccine’ –

“...a process of social and political mobilisation which leads to increased government and other institutions’ willingness to intervene with interventions, applied to populations rather than individuals, aimed at mitigating the structural social and economic conditions that make people and communities vulnerable to disease, illness and trauma. While medical vaccines help develop immunity against disease, social vaccines develop the ability of communities to resist and change social and economic structures and processes that have a negative impact on health and force governments to intervene and regulate in the interests of community health” (Baum et al, 2009).

The macro-structural framework of Benach & Muntaner (2013) situates employment relations in their larger institutional context. This is determined by social institutions and relations that ultimately respond to a global division of production, and the position of each country in the global geo-political order. This framework explains the effects of the distribution of political power (called “power relations”) on health inequalities through intermediary forces. The model begins with the interaction between political power relations (first column of the framework) and policymaking (second column of the framework). We concentrate on three locations of power relations, between industry and the state, between labour and industry, and between labour and the state. Policies relevant to our study include labour regulations, welfare state policies, as well as health policies that impact on the healthcare workforce. Labour regulation refers both to the specific regulation of the labour market (employment protection legislation) and to social benefits related to a salaried relationship, such as healthcare benefits, or income security measures for the unemployed.

Based on the evidence, our adapted model considers the area of occupation within the healthcare sector. The implications of the COVID-19 pandemic for health workers' health, quality of life and well-being are discussed subsequently.

We use the concept of 'care extractivism' to explore the commonalities, and particularities of the care economy and undervaluation of care work through an inter-sectional lens, as illustrated within the three groups.

For instance, among auxiliary workers we highlight the intersection of BAME (Black, Asian and ethnic minorities) and caste status with work lower down in the occupational hierarchy and among nurses and CHWs we discuss how low wages and poor benefits (e.g., childcare benefits) are partly a consequence of this work being seen as women's "natural" work. Similarly, social inequalities are identified both as structural determinants and outcomes of these processes. This framework is embedded within the broader context of health systems, and the political economy of healthcare. It explores the manifestations of global and country-level policies related to health systems and health workers of the last decades.

Methodology: Collective knowledge production as movement work

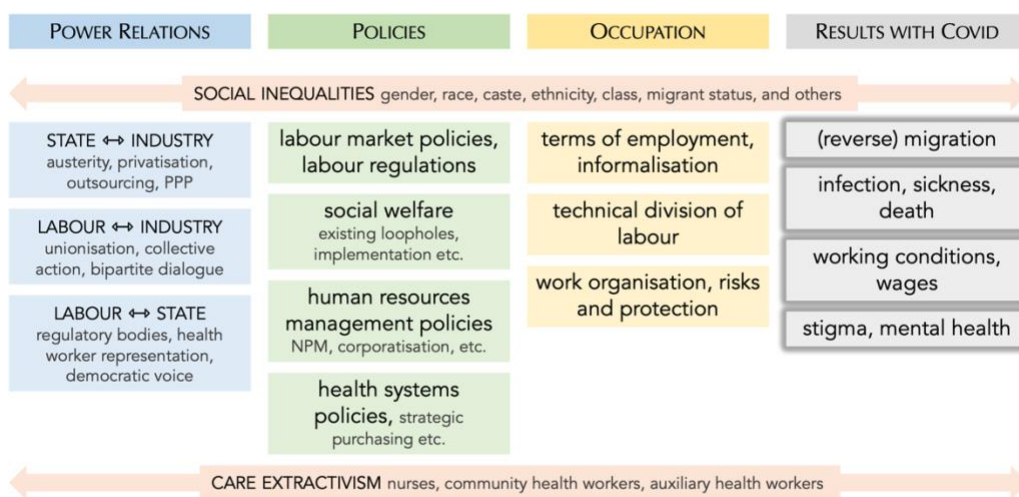


Figure: Theoretical framework to analyse the impact of the Covid-19 pandemic on health workers

This paper has contributions from activists, academics, and union members who are part of the People's Health Movement (PHM) and associated networks. Data was collected through literature review and participatory observation by the authors who are involved in campaigns and organizations demanding recognition for the rights of health workers in various countries. Secondary literature reviewed includes media articles; academic literature; blog posts and updates; petitions and statements issued by health workers and their unions; government orders; and policy documents by countries, UN agencies and other organizations. Case studies developed by PHM regional circles as part of a special call by the Health Systems Thematic Circle have also been reviewed.

Covid-19's impact on frontline health workers

NURSES: THE INTERPLAY OF GENDER, RACE, PLACE AND GEOPOLITICAL INEQUITIES IN CARE WORK

The world faced a chronic shortage of nurses even before the onset of the COVID-19 pandemic. The WHO's *State of the world's nursing report (2020a)* estimated that by 2030, there would be a shortfall of approximately 5.9 million nurses in health systems worldwide. Another cause for concern was the projected unequal transnational distribution of nurses :89% of the projected shortage is expected to be concentrated in low and middle-income countries (LMICs), while approximately 70% of the 8 million new nursing professionals (that the WHO expects will be trained by 2030) would be living and working in high-income countries (HICs). This resembles the current situation, where 81% of the 28 million nurses in the world are concentrated in only three regions, namely the Americas, Europe, and West Pacific (WHO 2020b).

The introduction and strengthening of international mechanisms such as the WHO's Global Code of Practice on the International Recruitment of Health Personnel can help regulate health workers' migration.

The intense migration of nurses from LMICs to HICs, and the consequent concentration of the vast majority of this workforce in the better-off regions of the world, has been a long-standing problem that has undermined the stability of health systems (ICN 2020). Together with widely implemented neoliberal reforms, this has contributed to sharp changes in working conditions (PSI 2019).

At present, 15.2% of the nursing workforce in HICs have been trained in other places (WHO 2020b). Currently, the triggers for nurses' migration are largely related to their inability to find adequate local employment, as jobs remain badly paid or otherwise precarious. Even in cases where they secure more adequate income after relocating, foreign-trained nurses are sometimes unable to secure a position in nursing. They end up working as nursing assistants or are employed in elderly and long-term care (Wichterich 2020) where they are paid less than nurses, and, more often than not, with significantly worse workplace protections than nurses. The introduction and strengthening of international mechanisms such as the WHO's Global Code of Practice on the International Recruitment of Health Personnel can help regulate health workers' migration. However, until adequate employment opportunities are provided in origin countries, it is unlikely that migration will stop. This can only be achieved through securing higher budgets for public health systems, and particularly for the health workforce.

Even though nurses are recognized as key actors in health care delivery, and their shortage is a concern on an international scale, their working conditions even in HICs steadily declined in the decades preceding the COVID-19 pandemic (Gordon 2005; Humphries, et al 2015), with an adverse impact on nurses' health (Llop-Girones et al 2015). Following the 2007 recession, many European countries introduced austerity measures with notable reductions of public budgets and social protection floors. As health systems in Europe are publicly funded, this resulted in a decrease of new jobs and de-standardization of employment (Alameddine et al 2012), pay and benefit cuts (Simou and Koutsogeorgou 2014), or stagnation of health workers' rights.

The same narrative played out in other parts of the world. Mexico, for example, reported an increase in precarity among nurses between 2005-2018 with regard to the percentage of people without a written contract; the percentage of people with incomes lower than two times the minimum wage; the percentage of nurses without social security; and the percentage of nurses without social benefits (Aristizabal et al 2019). Nurses in Croatia also faced de-standardization of their employment conditions: although rates of precarious employment have not risen as much in healthcare as in other sectors, following the financial crisis of 2007 it became more difficult for nurses to find and maintain employment even though trade unions have reported a lack of almost 12,000 nurses during this period (Butkovic and Samardzija 2016).

Austerity measures apart, the predominantly female nursing workforce (about 90% women) was severely affected by cuts in other fields of social protection, such as childcare and elderly care (Ćaćić and Levačić 2018; Dutchak 2018; Murphy and Cullen 2018). Patriarchal norms and social protection cuts during austerity intensified and often increased the workload of nurses. They received equal, or even less pay than before, which meant that the institutionalized care and reproductive support they needed had to be publicly provided (i.e., free or adequate to their income). However, the exact opposite happened. Social support mechanisms, such as home care for the elderly or kindergartens became increasingly privatized and, therefore more expensive, resulting in nurses facing an increase of reproductive work at home (ILO 2018a). The necessity for accessible and affordable social protection mechanisms became even clearer during the current pandemic. In some countries, nurses were forced to choose between ensuring care for their children and reporting to work. This issue was raised on several occasions by the Irish Nurses' and Midwives Organization (INMO 2020), who have argued that the lack of organized childcare for frontline health workers was additionally complicating the organization of work in hospitals (INMO 2020). In South Africa, even before the COVID-19 pandemic hit, only 5.8% of nurses had access to childcare facilities (Oxfam South Africa 2020).

Lack of PPE among nurses was reported all over the world – UK, USA, Malawi, Kenya, India, the Philippines, Spain, North Macedonia, and Croatia – exposing nurses to higher risks of infection.

The situation of already overworked nurses worsened because of the lack of personal-protective equipment (PPE) and governments' inability to offer an adequate response (El Diario 2020a). Lack of PPE among nurses was reported all over the world – UK, USA, Malawi, Kenya, India, the Philippines, Spain, North Macedonia, and Croatia – exposing nurses to higher risks of infection (El Dario 2020b; NYT 2020). Even though lack of PPE was widespread, it seems that in some places the presence of trade unions made it easier for nurses to petition management for additional PPE kits (Dean et al 2020), therefore securing safer working conditions.

Trade unions played a key role in the pandemic response by stepping up to advocate for nurses' working and health rights. On several occasions during the pandemic, international trade union confederations such as Public Services International (PSI) and European Public Services Union (EPSU) gave a call to ensure adequate funding and protection of nurses and other health workers exposed to the stresses caused by COVID-19 (PSI 2020; EPSU undated b). On a more local level, groups such as Nurses United in the UK have organized during the pandemic to argue for long-overdue pay rises (Nurses United undated).

The response to wage demands by workers and trade unions, in the best of cases, mostly came in the form of one-off COVID-19 bonuses. More often than not, in addition to inadequate remuneration, nurses faced problems with organizing everyday tasks as public services were disrupted. Similar to what was cited by INMO (2020) in the case of childcare in Ireland, for example, nurses in the Philippines and Georgia cited problems getting to the hospitals where they work because of the temporary suspension of public transport (PHM Philippines 2021; Solidarity Network Georgia 2021). More extremely, due to the stigma attributed to workers exposed to cases of COVID-19, nurses were victims of physical attacks and intimidation on a number of occasions (PHM Philippines 2021).

Migrant and minority nurses found themselves in a particularly precarious position due to hostile policy environments. In the UK, migrant nurses, along with other workers in the National Health System (NHS), had to pay an NHS surcharge pre-pandemic. Although the surcharge was temporarily suspended during COVID-19, issues arose when it came to prolonging their visas and securing their vaccinations (PHM UK 2021). In another part of the world, the United Nurses Association from Kerala coordinated the repatriation of Indian nurses stranded in Saudi Arabia, unable to return home after the beginning of the pandemic (Nursing News 2021). In what can be called a tragi-comic attempt of the British government to balance workers' requests for adequate pay and its dedication to austerity, a 1% pay raise for NHS workers was announced in March 2021 – approximately 14% less than what nurses' organizations have quoted as necessary to reach adequate remuneration (The Guardian 2021). In Spain, private health system nurses, not involved in COVID-19 related work, were sacked instead of being reassigned to duties that could have helped alleviate the pressure on health services (SAS Madrid 2020). The support measures in place have been inadequate, and far below the real needs of nurses engaged in the COVID-19 response (Government of UK 2020).

Instead of concrete support for their pandemic work, what nurses across the globe received was applause, which trade union officials have warned is not nearly enough (The Guardian 2020). Looking forward, it looks likely that in the aftermath of the pandemic, some governments might even look to additional cuts to nurses' salaries and health budgets as a short-term strategy for economic recovery (Alameddine et al 2012). This has been happening in South Africa for example, where blanket public sector wage freezes threaten to effectively reduce nurses' real incomes (Reuters 2020). However, this time it seems unlikely that symbolic recognition will suffice or that a reduction of existing rights will be taken lightly, as nurses' organizations cite industrial action [1] as a warning if governments and health officials fail to secure better working conditions and stronger health systems during COVID-19 recovery (EPSU 2021; RCN 2021).

COMMUNITY HEALTH WORKERS: AN INTER-SECTIONAL ANALYSIS OF NATURALIZING GENDER INEQUITIES IN CARE WORK TO EXPLOIT THE MOST VULNERABLE WHILE PRAISING THEIR EFFORTS

The deepening privatization, corporatization and neo-liberalization of the care economy has led to a reliance on the lowest end of the health hierarchy, the majority of whom are women (Wichterich 2020). Many countries, especially LMICs, have established CHW programs over the last couple of decades. According to the WHO, CHWs should be “members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers” (WHO 2007).

CHWs were considered to be important in achieving comprehensive primary healthcare (CPHC) as defined by the Alma Ata declaration of 1978 (Aye et al undated; PHM et al 2014). In the

India | ASHAs

In India, there are about one million ASHA (Accredited Social Health Activist) workers who are part of the national CHW program. The ASHAs are positioned as 'volunteers' (as per national policy) and are given task-based meagre incentives (Ved et al 2019). During the pandemic, ASHAs carried out critical tasks such as door-to-door surveillance, quarantine tracking, providing relief measures, and public health awareness, often without proper training on COVID-19, its symptoms, or methods of protection (Chatterjee 2020). They have persistently complained of shortage of PPEs and sanitizers; many ASHAs report having to buy these materials on their own, with no reimbursement¹. Meanwhile, the working hours of an ASHA has gone up from the usual four to five hours a day to nearly 10 to 12 hours with the additional tasks of expanded data collection and direct data entry through online means for them (Rao 2020).

In many places in India, ASHAs are facing violence and stigmatization within their families and communities, as they are seen as COVID-19 carriers and potential sources of infection (Rao & Tewari 2020). Despite this, the state has not only downplayed the risks they face but also fails to tangibly acknowledge their work – they remain underpaid and face delays in getting their regular incentives as well as those they were promised as part of the COVID-19 relief packages (Amnesty International India 2020; Rao 2020).

Additionally, routine grievance redressal mechanisms have become non-functional due to lockdowns depriving them of forums in which their problems can be discussed. One telling marker of their low status within the health system – The Indian Medical Association has released lists of doctors who passed away due to COVID-19 but there is no data on healthcare workers such as the ASHAs or sanitation workers.

early 2000s, there was a revival of CHW programs. In the preceding decades, the global south had faced the onslaught of Structural Adjustment Programs (SAPs) which wreaked havoc on public health systems, increasing shortages in human resources for health due to reduced public health expenditure. The World Health Report of 2007 highlighted the need for CHWs to fill the gap in human resource shortages through “task shifting” [2] (Aye et al undated; WHO 2007), particularly in the context of the HIV/AIDS pandemic (Schneider et al 2008).

CHWs, predominantly women from lower socio-economic backgrounds, are considered 'volunteers' and paid irregular salaries/stipends/incentives. Health policies often naturalize CHWs' work as “women's work”, consistent with patriarchal gender norms (King et al. 2020), obscuring and diminishing their status as workers and healthcare professionals in the process. Aye et al (undated) argue that the renewed interest in CHW programs is dominated by the neoliberal ideology which characterized labour of CHWs as either free or lowly paid and made to substitute a neglected and underfunded public health system. For example, in South Africa many CHWs are treated as volunteers temporarily working for stipends under government public works programs on short contracts. Their informal status and lack of professional recognition stunts their career mobility, leaving them trapped at the lowest levels of the occupational hierarchy, with public sector unions neglecting to organize them. This could be partly because unions do not consider CHWs to be health workers. They are thus effectively locked out of the policy- and decision-making processes that structure their work (Andrews et al 2020).

Globally, CHWs have been playing an important part in state responses to the COVID-19 pandemic and are involved in health education regarding prevention, conducting contact tracing, and assisting in quarantine and isolation protocols (Lotta et al 2020; Bhaumik et al 2020; Bezbaruah et al 2021). CHWs have also been critical in ensuring that the coverage of essential services does not decline during the pandemic, while facing harassment, discrimination and

South Africa | CHWs

In South Africa, the state has relied on the labor of community health workers (CHWs) to bolster its capacity to deliver primary health care efforts, central to its efforts to promote greater equity within the health system (Vale 2020, 15). It is estimated that at least 40,000 CHWs work in the SA health system – though some suggest the number may be closer to 60,000 (S27 and IEJ, 2019). Most of these workers are not directly employed by the government. Instead, they are typically employed by NGOs that receive government funding specifically for the purposes of employing CHWs that can work alongside public sector PHC facilities. The CHWs are predominantly black women who live and work in poor and marginalized communities. Though their work is described as essential, the workers themselves are treated as volunteers or activists who keep the spirit of social justice and *ubuntu* – both central to dismantling apartheid – alive in the post-liberation era. The government’s response to the COVID-19 pandemic relied on CHWs (Foster et al 2020). CHWs delivered both routine care, as well as COVID-19 specific interventions such as popular education, and assistance with test and trace services. They have been used to deliver chronic medication to patients who would otherwise have to make regular clinic visits to obtain their medicines, thereby risking exposure to COVID-19 (Brey et al, 2020). However, they are not involved in any decisions affecting them and there is little discussion of regularizing their employment status.

violence from the community and police during their work (Lotta et al, 2020; Rao & Tewari, 2020). Still, they continue to be denied fair and timely wages (Rao & Priya, 2020; Oloo & Mercy, 2020). We describe here the experiences of CHWs in South Africa and India (Rao, 2020).

As experiences in these and other countries show, CHWs have had to work without adequate PPE or training, despite the high risks of doing home visits that require close contact. Most Sub-Saharan African countries such as Malawi did not prioritize CHWs in their PPE allocation (PHM Malawi 2021). In South Africa, hierarchical hoarding of PPE and of insufficient access to PPE in both the public (Tomlinson 2020) and private sectors (Ho 2020; Jeranji 2020) have been reported.

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The South African government has declared CHWs as its “secret weapon” against the COVID-19 pandemic (Foster et al 2020). By 2025, an additional 97,000 health workers will be needed to ensure greater health equity nationwide, a third of which will be CHWs (Cleary 2020). Despite these declarations, there has been little progress in meeting CHWs’ demands for recognition as public employees, with full benefits and decent wages.

Significantly, CHWs have used their increased visibility and the South African state’s reliance on their labour during this pandemic to organize and mobilize for better working conditions (Hlatshwayo 2018, 2020; Foster et al 2020) – with limited success. In both South Africa and India, CHWs demanding adequate protection, just remuneration and formalization (EPW 2021) have faced repression by governments (PHM SA 2021; Lalwani 2020). In India, police reports have been filed against protesting ASHAs in Delhi.

In many countries, including South Africa, India, Malawi and Uganda, PHM chapters have been working with CHWs and their unions. Even through the pandemic, PHM supported them in highlighting the problems that they were facing. This was done through gathering of information and undertaking surveys for advocacy, organizing online events with participation of CHWs, and highlighting the issue in the media (PHM SA 2021; PHM India 2021; PHM Malawi 2021). In some instances, PHM chapters provided training and PPE to CHWs.

AUXILIARY HEALTH WORKERS: INFORMALISATION OF WORKERS ESSENTIAL TO THE HEALTHCARE SYSTEM HAVE RENDERED THEM INVISIBLE

pandemic gave greater visibility to some categories of health workers such as nurses and CHWs, but auxiliary health workers have not benefited from the trend. While there is no set definition of auxiliary health workers, we use the definition of workers in hospital auxiliary services, including dietary or catering, laundry, housekeeping, security services, drivers, and sanitary workers (i.e., cleaning and waste disposal). These workers mostly come from populations recognized as deeply vulnerable due to their gender, caste, race, class, ethnicity etc.

In the 1980s and 90s, the economic interventions of the World Bank and the International Monetary Fund (IMF) contributed to shifting the power relations between the state and the healthcare sector in several developing countries, by pushing austerity measures as well as private sector participation in social services, including healthcare. This led to informalization of employment conditions [3]. Since the financial crisis in 2008, austerity measures have also impacted developed countries (PSI 2019). Consequently, non-standard forms of employment increased as non-core health activities in public health facilities (i.e., auxiliary hospital services) were outsourced. In South Asia, public health facilities outsourced auxiliary services, such as security and dietary services, and implemented third-party contracting (i.e., contract employment) of less professionalized workers in the hospital hierarchy, such as sanitation workers (Basu 2016).

A similar process was seen in the UK in the 1980s during the Thatcher era (Scott Samuel et al 2014), which intensified after the financial crisis, with a £38 million reduction in funding for cleaning services over the last 10 years that led to the further outsourcing of staff (GMB Union 2021). Simultaneously, private health facilities multiplied where informal employment is widespread, including for auxiliary health workers (Akhter and Shimu 2016).

The insecurity of tenure, linked with informal employment, had a knock-on effect on power relations between employer and employee, both in the public and private sector. Unionization is low in auxiliary services, and often fragmented, which further decreases the bargaining power of existing unions. Demands for implementation of statutory requirements are met with threats of termination (Basu 2020). During the pandemic, this threat also extended to demands for implementation of work-place infection reduction protocols and guidelines (UMC & WaterAid 2020; Barria 2021).

There is little to counter this power imbalance in regulation or in representation of auxiliary health workers in government bodies. In many countries, auxiliary health services are inadequately regulated, especially where regulation of the private health sector is inadequate. Furthermore, we found no evidence of countries having regulatory bodies for auxiliary services with auxiliary workers' representation.

In many countries, informal employment conditions become a barrier to availing the benefits of labour market policies as well as welfare policies, as both rely on the ability to prove an

employer-employee relationship for access, or for remedy in case of denial (ILO 2020; Basu 2016; United Voices of the World undated). In the UK, outsourcing led to wage inequality and fewer employment benefits for hospital cleaners as compared to their counterparts directly employed under the NHS. In India, sanitation workers saw their workload increase without receiving compensation for additional workload and responsibilities (UMC & WaterAid 2020; Ashirvad 2020).

Various central and state agencies had introduced COVID-19 related support and welfare measures for workers. In India, these included compensation on death, monthly incentives, one time ration/cash support, financial compensation for sickness. However, informal workers were excluded from most such provisions (UMC & WaterAid 2020). Yet, during the COVID-19 period, improvement in working conditions of some auxiliary workers were achieved through the pressure from trade unions, such as in Spain and in the UK. In Spain, hospital cleaners were able to organize and assert their turn for vaccination as part of the at-risk category (Laura 2021; Elena 2021), and in the UK adequate pay and benefits for outsourced cleaning workers at par with their colleagues under the NHS was achieved through organizing in specific NHS Trusts (United Voices of the World 2020). Despite their important role, union busting was reported even during the pandemic (Amnesty undated).

The precariousness of the working conditions of auxiliary workers is linked to the contractual nature of their employment. In Asia's largest tuberculosis hospital, sanitation workers on contract are not provided with adequate personal protective equipment (PPE) despite the risk of contracting the illness through their work (PSI 2015). In continuation of this trend, PPE provision for auxiliary workers was found to be inadequate during the COVID-19 pandemic too. In India, few sanitation workers had access to PPE and where the PPEs were provided, it was late into the pandemic, or they were found to be of poor quality (Srivastav & Hathi 2020; UMC & WaterAid 2020; Ashirvad 2020).

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Neglect of this work category in accessing protection was also reported, including for vaccination during the pandemic. Workers who deal with COVID waste have been left out of vaccination in India (Rashid 2021). In Spain, cleaning staff in hospitals were left at the end of the essential workers' list for vaccination, despite the high risk involved in their profession (Martinez 2021). In many countries, this neglect also translates into a lack of investment, training or capacity building which results in worse outcomes even when provided with the required protection (Abdi et al 2021).

Socioeconomic factors also played a role in the health outcomes of auxiliary health workers, which has been termed by some as institutional racism (United Voices of the World 2020). In the UK, outsourced cleaning staff are overwhelmingly BAME, while most NHS workers are not. This meant that BAME workers were more exposed to risk of contracting the COVID-19 virus because of lack

of information, PPE, and management approach. In Singapore, where a number of auxiliary health workers are migrants, while rates of infection for healthcare workers were generally low, they were higher in auxiliary health workers compared with medical and nursing staff. In April 2020, significant outbreaks of COVID-19 were recorded in migrant worker dormitories (Wee et al 2020). Similarly in India, and most of South Asia, sanitation work is closely intertwined with the caste system wherein those belonging to historically oppressed castes form a large proportion of this workforce and face additional stigma (Srivastav & Hathi 2020).

Even within the same category of workers, women are facing worse employment and working conditions pointing to the negative impact of patriarchal gender dynamics. In India, the proportion of informal employment among female sanitation workers is higher than among male workers, and there is a considerable difference in the insurance coverage of male compared to female sanitation workers (UMC & WaterAid 2020; Ashirvad 2020).

Making the determinants of Inequity in the care sector visible

This paper documents the impact of COVID-19 on the three cadres of health workers who are located at the lowest level of the health worker hierarchy. The framework helps to link the immediate impacts on health workers during the pandemic to its broader determinants. It demonstrates how power relations embedded in existing social inequalities such as gender, class, caste, migrant status and ethnicity have profoundly shaped global discourse and country-level policies of the last few decades related to health systems and lower-rung health workers. The application of Wichterich's (2020) concept of 'care extractivism' further exemplifies these dimensions within the care economy and the social reproduction.

SOCIAL INEQUALITIES INTERSECTING WITH HEALTH WORKER HIERARCHIES AND POLICIES AND PRODUCING FURTHER INEQUITY

The division of labour within the health system assigns the jobs considered of 'lower' importance to women and socially vulnerable groups and communities that have been historically marginalized such as indigenous people, Dalits, and migrant workers, and policies fail to protect them or provide them with decent work. Women form the bulk of health and social care workers (the global figure is 70%) but are clustered in the lower rungs of the hierarchy (e.g., the proportion of female doctors in OECD countries is 46%) (WHO 2019). While CHWs face greater vulnerability due to their gender and lower socioeconomic status, auxiliary health workers face disadvantages due to their social status as they are often from the most marginalized communities such as BAME, Dalit and migrant communities. Even in the case of nurses, whose profession is the most recognized among the three, their position is often subordinated to that of the physicians. In the pandemic, their contribution has been overlooked in several instances in favour of physicians' work, even when they are bearing most of the workload and have been more exposed to COVID-19 infection in hospital settings (Bandyopadhyay et al 2020).

While there are slight variations within these three cadres in terms of the issues and intensity of the problems faced by them during the pandemic, the experiences among all three cadres show that they have had inadequate access to PPE, resulting in a large number of infections and deaths among them. Within hospitals, auxiliary health workers face a higher risk of infection than doctors and nurses and social inequality made some even more vulnerable. In the community, CHWs face a high risk of infection as they regularly come in close contact with others to provide counselling or healthcare. The nursing cadre is relatively more formalized and organized than the other two and able to push demands. However, more often than not, data related to auxiliary health workers or

CHWs is not being collected. For instance, while in many countries, medical and nursing associations have made lists of doctors and nurses who have died, similar data is not available for CHWs or auxiliary health workers.

This reflects their position in the health worker hierarchy and labour market policies and regulations reproduce these existing social inequalities through legitimizing outsourcing and informalization of community based primary healthcare and auxiliary health services. Because of the intersection of their marginalization along at least three axes – occupational status, social status and associational status (unionization) – these workers find it more difficult to secure recognition for their demands for equal treatment as health workers.

Health workers have been identified as the group with "high to very high risk of acquiring and transmitting infection" and been accorded highest priority for vaccination (WHO 2020c). However, stark inequity is being seen in global access to vaccination among countries (Rouw et al 2021, BBC 2021). While in the high-income countries (mainly in Europe, Americas and Asia) vaccine rollout has commenced for health workers, till March 2021 there were about 100 countries (mostly in Africa) where not a single health worker had received vaccination (Kupferschmidt 2021, Amnesty 2021). At the time of writing, most health workers in Africa remain unprotected; many are dying as rich countries are buying up and administering COVID-19 vaccines (Kupferschmidt 2021).

Among LMICs, countries such as India have made reasonable progress in prioritizing and vaccinating its health workers (Babu 2021). However, concerns continue to be raised in many countries on the risk of health workers missing out on prioritization, or being forced to wait, either because of a lack of supply, problems in implementation, or narrow definitions of what constitutes a health worker (Amnesty 2021). Even in HIC, auxiliary health workers, especially migrant workers faced issues of exclusion and had to assert themselves to ensure they are prioritized. For instance, migrant nurses, and other workers in the National Health System (NHS), faced problems in securing their vaccinations (PHM UK 2021). In some countries unions and employers also had to advocate for home-based care workers to be formally defined as health workers so they could be included in the first groups prioritized for vaccination (Amnesty 2021).

“CARE EXTRACTIVISM” AND THE “CRISIS OF CARE”

Care extractivism, as an expansion of the inequality axis, “marks the intensified commodification and exploitation of the resource labour in social reproduction for the purpose of managing crisis situations without burdening the state or the health industry with additional costs and responsibilities” (Wichterich 2020:122).

It integrates and stresses the structural power relations in the analysis of inequalities. For instance, the spirit of volunteerism and activism expected in community-based women workers, declining formal employment opportunities, and patriarchal power relations push women to work in under-compensated part-time roles as CHWs. Patriarchy and cuts in social protection heightened the workload for all women workers in lower-rung categories, as has been illustrated through experiences among all three groups.

The burden of social reproduction created a double whammy for women health workers during the pandemic. This ‘crisis of care’ is not new, but the pandemic has exacerbated it (Fraser 2016; Chang 2020). Lockdown restrictions and closure of schools, crèches, free meals for children and other support institutions increased the burden on women to provide care to children and their

other relatives. As essential workers they were expected to go out and work, but also provide most of the unpaid domestic work within the household, with any previously available support system being unavailable or very expensive. The crisis is more severe for women from lower socioeconomic classes, BAME and migrant communities as they constitute a higher proportion of such workers (Jaffe 2020; UN Women 2015). Social reproduction work in households, including care for the sick or disabled, has historically been naturalized as the individual responsibility of unpaid or under-paid women. As the paper shows, this has extended into the health workforce.

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DEVASTATING CONSEQUENCES OF INFORMALIZATION OF LABOUR

All cadres have faced expansion and intensification of the workload in the time of the pandemic, without adequate compensation. In most cases, this increase has not been negotiated. The steady informalization of work has contributed to the deepening vulnerability facing health workers today.

Informal workers are more prone to be assigned riskier tasks, while they have least recourse for protection, including adequate PPE and social security measures. Delayed and inadequate wages along with sudden loss of employment and lack of social protection due to informality in occupation led to serious financial crisis within their families. There has been uncertainty over and exclusions from entitlements, including testing, sick leave, and vaccination. Health workers faced stigma, discrimination and violence from both the community and the state while doing their work. Often contractual/informal workers are unable to voice their concerns due to fear of losing their jobs.

This has contributed to a rise in mental health problems among health workers which have largely gone unidentified and unattended. Women workers, such as CHWs, have found it difficult to access mental healthcare services due to stigma and lack of access to such services. Auxiliary health workers are often deterred from utilizing mental healthcare services even if available due to their even more precarious status.

LEGAL REGIMES AND POLICY RESPONSES BY GOVERNMENTS

Governments have had different approaches to protecting health workers during the pandemic, ranging from one-off financial bonuses to recruitment of volunteers and workers from other countries (Williams et al 2020). Only a small number of countries put in place a wide range of measures to mitigate the negative effects of the pandemic on health workers. Even a significant proportion of HICs avoided taking concrete steps to support nurses and other healthcare workers during the pandemic. In WHO’s European region, in the cases where support measures were introduced, they consisted of a combination of mechanisms to support health workers’ mental health, provide financial compensation for COVID-19 related work, and ensure available childcare, transport, and accommodation (Williams et al 2020). However, given that countries had differing ideas of what support consists of, it remains to be seen whether the measures reported will have a positive long-term impact on health workers.

Health worker unions and people's movements came together to demand the protection of health workers' rights during the pandemic and beyond. In some instances, such mobilizations have faced repression by governments, leading to termination of work and other penalties.

Demands around rights of health workers have been undermined through a discourse that exalts health workers for their public service, without discussing their needs and rights. The insecurity of tenure linked to informality creates a barrier to demanding that existing protocols be followed. Moreover, for cadres such as the CHWs the expectation of selfless social service by community and government has made it difficult for them to voice their protests and demands. CHWs and other cadres lower in the hierarchy have been left out of policies providing additional financial support in most cases (Bezbaruah et al 2021). There is absence of or limited subsidizing of the infrastructures CHWs need to do their jobs safely and effectively (e.g., transport, meals, uniforms, staff rooms in clinics). Fair remuneration and decent working condition, services such as childcare, food support, and transportation could have ameliorated some of the problems faced by health workers. But these were lacking in most instances. This links to the broader social protection measures and public services that are available in any country.

This situation is enabled through national laws allowing commercialization and privatization of public health facilities, international laws requiring "free trade" in health services and international financial institutions being permitted to require austerity cuts as preconditions for loans aimed at "development" and "stabilization" of sovereign states' economies. Within countries, the social construct of care-work, social inequalities, and legal regimes that do not recognize certain categories of workers and therefore do not mandate minimum wages and social protection for them perpetuate this situation. For CHWs fragmentation of the workforce prevents them from organizing. In case of nurses, only 41 countries have ratified the International Labour Organization (ILO) Nursing Personnel Convention, 1977 (No. 149) and the accompanying Recommendation (No. 157) that set standards for fair employment conditions for nursing personnel.

CRITICAL ROLE OF THE WELFARE STATE AND PUBLIC EMPLOYMENT

The de-funding of the public sector and reduction of social sector budgets and reduction of public employment have been seen since the SAPs. The privatization of essential and public services such as education, healthcare, transport have made them more expensive and exclusive. Universal social protection measures are being narrowed and targeted through citizenship laws and mandatory identification papers, leading to exclusion of undocumented migrants, indigenous communities and others who find it difficult to produce any papers or proof of identity.

The more protection people receive from the welfare state, the higher the level of "decommodification" of labour.

As described in the paper, the implications of privatized and contractual systems for health workers are disastrous. Both regular employment and public employment have huge benefits for labour rights, especially for women workers and for the people receiving the services (Sinha & Shriyan 2021). The welfare state and the labour market are deeply intertwined. The more protection people receive from the welfare state, the higher the level of "decommodification" of

labour. Decommodification is the extent to which workers are able to fulfil their social and basic needs when they find themselves out of a job.

POWER RELATIONS BETWEEN STATE AND INDUSTRY

The power relations between industry and the state are defined by a political intention to regulate the role of the state and the private sector in healthcare. Most countries have done this through liberalization accompanied by austerity measures and more explicit forms of privatization of health services such as outsourcing, and public-private partnerships (PPP). Austerity policies and unregulated commercialization of healthcare services have led to reliance on informal and unpaid labour, worsening working conditions, voicelessness, and lack of a clear professional trajectory.

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There is a push by international agencies such as the World Bank for governments to “purchase” health services instead of providing them. Such ‘strategic purchasing’, often done under the universal health coverage (UHC) discourse and under the guise of regulation, has commodified healthcare, undermined the already neglected public health system in many countries, led to the transfer of public funds to the private sector and regulatory capture by the private sector, impacting health workers further (Sanders et al 2019). For instance, outsourcing auxiliary services of public facilities to the private sector creates a gap in working conditions of auxiliary workers compared to other workers in the same facility.

POWER RELATIONS BETWEEN WORKERS, STATE AND INDUSTRY

The power relations between labour and industry are captured by relations in unionization, bipartite dialogue, and collective industrial actions. Representation in government bodies and structures for health workers’ democratic voice in government decision making are essential elements. The paper shows that organizing provides strength to health workers to articulate their demands and pressurize governments and others for a response. It has also been seen that improved working conditions are an outcome of industrial action and are a contribution to improved quality of care. However, informal workers find it challenging to unionize due to their work circumstances. For instance, CHWs have historically been neglected by trade unions as the sector is highly fragmented, and informalized. Moreover, their work takes place within private households. Among auxiliary health workers there is very high incidence of informal employment conditions with insecurity of tenure that worsen the power relation with the employer, whether public or private.

During the pandemic trade union representation among nurses has made a difference as trade unions fight for better access to PPE and other forms of protection during pandemic. Some nurses are also already organizing for long-term improvements during recovery. One study has found that mortality due to COVID-19 was lower in hospitals where the nurses were unionized, enabling proper provisioning of PPE and other support (Dean et al 2020). Unions and associations of CHWs (wherever they have been formed) were supported by civil society organizations, trade unions and media to highlight their plight and demands. This experience underlies the importance

to establish a link between professional nurses and other cadres to work collaboratively, and to challenge medical hierarchy.

As vaccines are rolled out in high-income countries, the pressure on the health workforce globally is not reducing. It is more than likely that the effects of this pandemic on the lives and work of health workers will continue to linger long after it winds down. There needs to be public recognition of the fact that the dismantling of public health systems and labour rights has been devastating for health systems, health workers and peoples' health and wellbeing, as also well illustrated in the pandemic. Therefore, while intervening on the proximate impacts of the pandemic on health workers and the health system, a discourse emphasizing the significance of public systems and services, changing political power relations towards social justice and equality and a fair redistribution of economic resources must be at the crux of any long-term vision and struggle.

Policy Recommendations

The COVID-19 pandemic provides an opportunity to acknowledge the significance of CHWs and recognize their rights. Governments must provide decent work for CHWs, with fair wages, social protection, training, and a conducive working environment (Aye et al undated). The health system needs to be strengthened to respond to demands from the community that CHWs are faced with and for CHWs to function effectively within the comprehensive primary healthcare team.

1 RECOGNIZING THE IMPORTANCE OF PUBLIC SERVICES, INCLUDING THE HEALTH SECTOR

- Governments should recognize the essential role played by public services before and during the COVID-19 pandemic and ensure that this recognition is reflected in public sector policies to be developed in years to come.
- Governments and international organizations should recognize and act on the structural drivers of inequality that push the more vulnerable groups into more precarious and exploitative work.

2 RESTORING AND INCREASING PUBLIC HEALTH INVESTMENTS

- International organizations should promote funding public budgets, and not impose austerity measures and cuts to public budgets, especially in LMICs. Global organizations such as the World Bank should drop their fixation with restructuring, austerity, and PPPs. The current framework harms nurses through significant cuts in their salaries and limiting access to social protection mechanisms.
- Focus on financing public sector during COVID-19 recovery: all public services and social protection mechanisms should be funded adequately and reflect actual needs. Kindergartens, homes for the elderly, public transport and public housing should be adequately funded.
- Invest in public health systems and roll back austerity policies, to reflect the essential nature of the health workforce, especially nurses, CHWs, and AHWs, rather than treating them as a supplementary workforce that can be hired and fired with little consequence.

- Lift existing caps on employment in the public sector and prioritize standard employment of nurses in public health systems to arrest high drop-out rates from the profession due to overwork and precarity in employment.

3 ENSURING ADEQUATE WAGES, SOCIAL PROTECTION TO HEALTH WORKERS, REVERSING OUTSOURCING

- Promote and support initiatives to reverse outsourcing in health facilities. Outsourcing has proven to have detrimental effects on workers' rights, especially in the case of auxiliary health workers, including their ability to organize and the right to decent pay.
- In the case of the nursing workforce, building back better will have to mean the introduction of policies based on increased public budgets, more employment (Public Services International, Undated) and accessible nursing education. Steps must be taken to minimize negative effects of nurses' international migration on health systems and countries in the Global South. International mechanisms put in place to regulate migration of health workers, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel, should be made binding for WHO member states.
- Pressure must be exerted by the international community on all countries to ratify the Nursing Personnel Convention, 1977 (No. 149).
- Put in place international and national enforceable standards along with the declaration of COVID-19 as an occupational disease.
- The work of recruitment agencies has to be evaluated and regulated better to ensure that there is no syphoning of nurses from LMIC to HIC, and that migrant nurses recruited through these agencies are guaranteed adequate living wages and good conditions.
- Put in place migration policies which are not discriminatory and punitive, and ensure that migrants, including migrant nurses and auxiliary health workers, can access all necessary services without financial penalties or threat of deportation. Migrant nurses and auxiliary health workers have to be paid the same, and have the same benefits, as local staff. Adopt national health workforce strategies based on actual needs: health workforce planning has been disregarded for a long time, it is necessary for governments to approach this in a more responsible way – find out how many nurses are actually needed for safe functioning of health systems, and act to staff health systems accordingly.
- Ensure that nurses are paid adequate living wages in line with pay rises that were skipped in the aftermath of the 2007 financial crisis, especially in the global south.
- Implement regulations that ensure all CHWs, whether in private or public employment, are paid decent wages on time, enjoy good working conditions and benefits, and are able to play a meaningful role in decision-making processes.

4 PRIORITIZING TRAINING, FORMALIZATION OF POSITIONS AND CONTRACTS

- Prioritize local training of nursing staff: ensure that nursing education is accessible free of charge in order to enable working class people to train and practice as nurses. This can encourage people to become nurses, strengthen health systems, and ensure good living

conditions, in addition to supporting social equity and promoting good standards in employment.

- Recognize community health workers (CHW) working within the government as public sector workers and ensure that the health system offers all CHWs a clear and practical professional trajectory

5 UNIONIZATION, COLLECTIVE BARGAINING AND WORKERS PARTICIPATION

- Promote and protect the right of nurses, CHWs and auxiliary health workers to organize and join trade unions. Include their organizations and trade unions in planning health systems and promote labour organizing among these cadres. This helps empower workers and has a positive effect overall on organization of work and the functioning of health systems.

Notes

[1] Industrial action refers to organized workplace action, as a strike or go-slow, taken by a group of workers, to promote what they conceive to be either their own interests or the general public good.

https://pure.ulster.ac.uk/ws/portalfiles/portal/85889667/Defining_Industrial_Action.pdf

[2] “Task shifting is the name now given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers.” https://www.who.int/healthsystems/task_shifting/en/

[3] We use informal work interchangeably with the ILO concept of non-standard forms of employment which covers work that falls outside the scope of a standard employment relationship of “full-time, indefinite employment in a subordinate employment relationship”.

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