# Care and its multiplicity of burdens

I would like to preface this by stating that I am in no way a healthcare worker. I have no personal experience with the situations you as individual healthcare workers find yourselves in, however, I do hope that I can offer an interesting perspective and some food for thought on situations you may relate to.

I have a background in the social sciences, a field where lived experience informs much of our societal understanding. The process of listening to and observing others and critically engaging with and analysing the information they impart has been ingrained into my very way of being. This has helped me recognise the real-life existence of book-bound theories and understand their manifestation in society. In light of this, and the COVID-19 pandemic, I present to you my thoughts on care, its complexities and the multiple burdens involved in providing it.

Pivotal to this piece is the notion of burdens. The overburdened healthcare system, burdens of disease, burdens of care; these concepts are commonplace in the narrative on the provision of health care, especially in the South African context. These concepts permeate public debate on the provision of health care, underpin public health and policy decisions on the provision of health care, and arguably ignore a counter argument. While there is certainly a burden on the healthcare system, the result of a historical legacy and its subsequent impact on the social determinants of health, the healthcare system is itself a burden. There is a burden on the healthcare system and the burden the healthcare system poses to those within it to contend with. These ideas do not exist in opposition to each other, rather they reinforce each other in a cyclical manner.

The first time I encountered the concept of a burden of care I was in a first-year sociology course. The module was called "recognising care, respecting the carer," in a course on the individual and society. Burdens of care, the struggles faced by caregivers, were explained in reference to community healthcare workers who provide care to those living under difficult socio-economic conditions and yet, they are part of that same social context. These community healthcare workers illustrate the complicated care/burden relationship. They provide care in an overburdened system while simultaneously being burdened by that system.

Accepting that the South African healthcare system is overburdened is easy enough. It is the overarching narrative of this country as demonstrated by government, the media and citizens who work in and utilise the system. Limited resources, be it staff, infrastructure or necessary goods and products have to contend with a quadruple burden of disease and increasing patient numbers in the quest to provide health care. The COVID-19 pandemic has highlighted the tenuous situation the healthcare system finds itself in, forcing us to recognise disparities within the dichotomous public and private healthcare systems and the lived realities of the majority of South Africans (which are imbued with racial, classist and gendered undertones). The question of how South Africa's quadruply overburdened and under-resourced healthcare system would handle COVID-19 went so far as to move national government to take such austere prohibition-style measures in order to keep hospital beds open. COVID-19 has certainly had an effect on the country (and the world). It has decimated economies through skyrocketing rates of unemployment and ravaged markets. The social, tactile nature of the human condition has been rendered obsolete, replaced with anxiety and a strange mixture of complacency, cooperation and defiance.

COVID-19 has been illuminatory in many ways. It has taught us lessons about preparedness, government capacity and government will, societal contracts and trust in a system. It has highlighted inequalities of care both between and within countries while also illustrating that traditional conceptions of government capabilities are not as they seem. It has taught us about human kindness, human nature, and human action. It has exposed the bare bones of society and demonstrated the need for change; change in the way we treat the environment, in the way we work, in the way we enable and ensure access, and in the way we provide health care. Most pertinent to this piece is the fact that it has taught us lessons about the realities of providing care and the hardships and sacrifice faced by those who do so. The burden of the healthcare system on those who interact with it has been revealed in explicit detail.

A thought exercise: When you think about your job, what type of work do you see yourself doing? What type of labour do you perform?

I would argue that as healthcare workers you perform, at least in part, intimate labour. Intimate labour is a broad concept and, at a brief glance, can be explained to encompass a wide range of activities including upkeep, personal and family maintenance and sexual contact. It entails touch, physical and or emotional closeness, familiarity, observation and knowledge of personal information, all of which are actions which address the needs of others. Intimate labour is often considered in terms of domestic and sex work which has a low economic value and while that is likely inapplicable, intimate labour is also accepted as happening when caring for the ill and infirm in places such as hospitals.[1] Intimate labour is care work, and though I assume you are taught to and encouraged to divorce yourself from the personal and emotional aspects of your work, you are still human and susceptible to human emotions. In caring for others, at what is often a vulnerable time, you make yourself vulnerable as well. Every day you care for others, making decisions that may result in morbid consequences, accepting some portion of responsibility for potentially painful outcomes, placing your physical, emotional and mental health on the line in order to uphold a sacred oath. All this for people who, for the most part, have no understanding of the hardship and sacrifice involved in this contract.

COVID-19 has, unintentionally, provided a window into your world. Media platforms have been awash with harrowing images of healthcare providers exhausted, bruised and emotionally spent, and stories of healthcare providers moving out of family homes and falling ill and dying. This explicit visualisation of the work done by healthcare providers has humanised a field often held to higher standards and inspired compassion and gratitude for their services. It has made it known that there is a burden in providing care.

And so, I thank you for your service.

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## Reference

1. Boris E, Parreñas RS. Introduction. In: Boris E, Parreñas RS, editors. Intimate labours: Cultures, technologies, and the politics of care. Stanford, California: Stanford University Press; 2010. p. 1-12.