

Health care system and situation of nurses and midwives. Against the race to the bottom¹

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Health care system in Poland is usually viewed as insufficiently functioning. The Polish hospitals for a long time struggled with the problem of constant debts as they tried to provide medical services within not sufficient budget.

The changes in the health care system cannot be viewed simply as an effect of the austerity policies, since their history is far longer. However there are visible similarities in the policies introduced into Polish health care system, which are based on the New Public Management policies and establish further cost reductions, usually in cost of workforce. For last 20 years the health care system workers made many attempts to introduce the knowledge about their working conditions and wages into the public debate. The occupational group that significantly highlighted the connection between working conditions, wages and the quality of care were the nurses and midwives. They organized their own trade union, which uniquely combines the agenda of quality of care with militant actions.

The aim of the article is to analyse the forms of protests taken up by Polish nurses and midwives and their trade union, in the context of the specifics of care work. Therefore the changes in health care system can be viewed from the gender relation perspective, an approach with a long tradition in case of nurses and midwives work of Ehrenreich (1978), Gordon (2006), Isaksen (2009), Priegert Coulter (1993), Roberts i Group (1995), Walby (1994), White (1990). It enables better understanding of forms of protest organized with strong regard to care for patients and the quality of health care services, which is an effect of deeply internalized ideas and values of care work, in connection to notions of woman's protectiveness.

Health care system reform

The reform of finance in health care sector in 1999 introduced a system based on insurance funds (Włodarczyk 1999, 2010). It aimed to replace budget financing with financing based on subscriptions collected in taxes. The 17 Health Funds (16 regional and 1 branch), and after 2003 one National Health Fund contract medical services and control their performance. The Health Funds did not provide financing for hospitals. They ordered and paid for certain services: medical treatment, operations, and patients' stay in hospitals. The head manager of hospital (which was transformed to "independent public health care unit") is responsible for division of means obtained from the contract (with Health Fund and the National Health Fund): wages, repairs, purchases of equipment. This radical change was criticized by trade unions in health care sector. As Jane Hardy, Alice Stenning (Hardy i Stenning 2005, Hardy 2009) and Wiesława Kozek (2010) point out the reform was based on the processes of decentralization, rationalization and introduction of market mechanisms to public services and institutions, according to the rules of New Public Management: the calculation of costs in delivery and organization of health care,

market mechanisms in management and financing health care. The final effect of market mechanisms in health care sector is the obligatory commercialization – transformation into companies, which is interpreted as a first step to privatization of hospitals.

The health care system reform included restructuring of employment. In many hospitals about one third of workers were laid off (Hardy, Stenning 2005). The numbers of patients did not change. Therefore those nurses, who kept their jobs, faced new phenomenon –exceeding work overload. The intensification of work was not connected to the pay rises. Just after the introduction of the health care reform in 1999, the wages of nurses did not enable them to live on their own. The reform caused the increasing income gaps in health care. Since 2000 when wage negotiations were transferred on the level of health care facilities (hospitals, clinics, etc.), the level of wages depend on various conditions: the level of wages on local labour market, the managerial policy (investments in technology or investments in human capital), on the workers representation and the decisions of nurses' management.

Working conditions

Low wages form a pressure to seek for additional employment. In 2000 nurses usually worked as cleaners. Currently, since the number of nurses is decreasing and more of them retire than start the career (according to National Chamber of Nurses and Midwives data), the additional work within the occupation is possible as a part-time job. Depending on the local labour market offers, they work in home care, public and private clinics, in hospitals – also at wards that demand intensive integration with the rest of the team. For example in one vojevodship capital the new academic hospital employs only three full-time nurses on neuro-surgical ward. The rest of nurses work on contract of mandate, after full-time work in other hospitals. The hospital managers often do not create new full-time jobs and do not increase wages but offer additional, fragmental employment, which enables cost reduction. There is also no competition for nurses by increasing the wages to attract nurses with rare specialisations.

The hospitals managers offer the cheaper contracts of mandate, regulated by Civil Law and not the regular contracts of employment. This solution forefends good quality of care work. The nurses cannot make a deeper contact with patients; they also do not have time for health prevention. They are more tired because they work more than full time therefore the risk of mistaking the medicines is higher. The statistics presented by National Chamber of Nurses and Midwives shows the scale of overload experienced by Polish nurses. The number of employed nurses and midwives per one thousand citizens is 8,1 in Czech Republic, 7,5 in France, 9.6 in Germany and 9,2 in United Kingdom. In Poland it is 5,0.

Nurses' ratio

The nurses attempt to publicize the issue of nurses' ratio, which is a regulation of minimum manning on the ward. It is a problem recognized internationally. As Susan Gordon, John Buchanan and Tanya Bretherton (2008) wrote, the debate on the adequate number of patients per one nurse is directly connected to the health care systems reforms introduced in 1990s. The strategy of cost cutting bounded on nurses, who were evaluated as a too numerous group. The work intensification was followed by the shortening of time spent

at hospital by patients. In the view of nurses this mechanism divests the patients proper, good quality care and nursing, which has to take time. Intensification of work jointly with lack of possibility to offer good quality care results in high frustration among the nurses and anxiety that they will not be able to take care of the patients properly. In Poland the cuts in employment and lack of nurses' ratio result in more threatening situations for the patients; one nurse is responsible for 20 to 30 patients. In case of long-term care clinics one nurse is by herself on the ward on the night shift. This kind of cuts, which are an effect of pursuit to economic efficiency and cost reduction, may form a threat to patients.

Minister of health introduced the mechanism of calculation of nurses' ratio in 1999. It was a complicated algorithm, which assumed six months observation of work, personnel rotation and intensity of patients. According to nurses it was very difficult to conduct observations in conditions of work intensity and without an IT program to facilitate the task. In 2012 the All-Poland Trade Union of Nurses and Midwives and the National Chamber of Nurses and Midwives with the Ministry of Health started the new round of debate. After very long process of consultation the Ministry proposed new scheme, which was supposed be based on the proposals formed by both nurses' organizations. Nonetheless, according to nurses, the Ministry's proposal does not solve basic problem of minimum number of nurses on wards.

However, the key is in the norms included in the contracts offered by National Health Fund. In case of doctors, the NHF exacts a certain number of different specialist and makes it an obligatory condition. However there is no required minimum in case of nurses. What is more, the NHF offers general contracts, without indication about the share of contract into different categories in hospital budget. Therefore it is up to hospital managers to decide if they will invest more in technologies or in the human capital – and in which occupational groups. As nurses point out, the job evaluation in hospitals is quite significant – the responsibility for the diagnostic technologies is valued higher than the care work. Additionally, there are relatively more investments in the medical technologies than into care technologies that would support nurses' work (man lifts, levers, rotators) (Faraj 2002).

If the hospitals managers wanted to employ nurses only on the basis of contracts of employment, it would quickly turn out that there are not enough nurses on the labour market. However none of the institutions responsible for health care and working conditions – State Labour Inspection, National Health Fund, and Ministry of Health – does undertake the challenge of proper calculation of all employed nurses and confronting the number with the number of offered jobs.

Self-employment

The relatively new phenomenon in the health care system is the introduction of self-employment in the place of full-time jobs. This solution was officially confirmed by in the set of medical acts passed by Parliament in 2011 – self-employment was presented as an example of freedom of choice of form of employment. It is beneficial for the employer as it brings further cost reduction. The solution of self-employment was introduced even in hospital that were not privatised or commercialised. In public paediatric hospital in Chor-zow (Silesian region) the self-employment was introduced gradually, ward after ward.

The line of argumentation presented by the managers always revolves around cost reduction for the hospital and at the same time, higher incomes for the nurses. However the

details prove that the situation of nurses does not improve significantly. Self-employment means that they sign a contract with the hospital, which is not under the protection of Labour Law and under no working time restrictions. They are obliged to pay for their social security and tax, usually contract out an accountant who runs their books. The self-employed social security rent is flat and low, the same for all self-employed, which poses a threat for their future on retirement. Self-employed are not entitled formally to paid holiday and their sick leave is less beneficial comparing to the contract of employment. More recently, a hospital in Rzeszow (Southern-eastern Poland) announced an open tender on the duties of specialist nurses. The proposed amount of contract: 2520 PLN was at the same level as the usual employment wage counted after tax, which was formerly offered in the hospital the difference is in "gros – net". In case of this offer, the nurse should pay by her/himself social security, health insurance etc, so in the end, the new contract proposed by hospital worsens the working conditions and wage.

Although the self-employment is presented as a cost-cutting strategy in hospitals, it should be rather interpreted as a strategy of postponing important costs – individual and social. The self-employed nurses work much more hours than the Labour Law regulations, sleep between the work shifts in staff room. There are no state regulations that would limit their work time or would pay attention if they take proper holidays. According to Polish trade union law, the self-employed cannot be organized by trade unions so the cost-cutting strategy is as well an anti-union strategy.

Strategies of resistance

Nurses and midwives attempt to counteract to unwelcome changes in the health care system and to introduce their point of view and experiences in public debate. Their most recognised worker representation organization is all-Poland Trade Union of Nurses and Midwives (OZZPiP), with 20 years of activity history. All the health care sector workers face the dilemma on the choice of a form of protest that would not harm the patients and that would be visible at the same time. The nurses and midwives trade union seeks to form a model of resistance that would publicize their problems and demands without any risk to patients. They argued that there is a strong link between the working conditions and wages of nurses and the level of quality of care for patients. What is visible in case of nurses' protests is the very much-underlined connection between the character of the reform and the possibility to offer the best quality care work to patients. It may be interpreted as part of the occupational socialization. As Rebecca Priegert Coulter (1993) writes, the nurses are trained in holistic and individualized approach to care work. This approach stands in opposition to transformations in health care system, which is directed by the pressure on economization of services. Strikes and protests of nurses in Poland are therefore similar to reactions to changes in health care system showed by nurses in other countries.

All-Poland Trade Union of Nurses and Midwives (OZZPiP) launched many protest actions. In effect of the transformation of public hospitals and clinics into independent units participating in the bids announced by National Health Fund, the social dialogue and protests were transferred to the hospital level. The protests after 2001 had therefore mostly local character. The significant exception was the White City protest in 2007, a coordinated strike in five hospitals in one region that was negotiated on ministry level in 2010 and a protest action in Polish Parliament in 2011.

The profile of protests organized by OZZPiP is very specific. The trade union can be characterized as militant (Kelly 1998), depending on the mobilization of all members and a transformational character of the agenda, which in case of nurses and midwives translates to a new vision of a health care system that provided good quality care and resigns from “race to the bottom”. All employees of health care system face the dilemmas of choice a proper of protest, which would not be harmful for the patients and would be publically recognized. In case of nurses who work closely with patients, the decisions are perceived as dramatic. Their main rule is to organize a protest, which would have minimum negative impact on the situation of patients and the activity of hospitals. It is quite paradoxical assumption for a workers’ protest.

It can be interpreted in terms of ethics of care (Gilligan 1983) and high responsibility of nurses. There is a significant difference between the strikes and protests organized in Poland and for example in US where the hospital management decides to hire additional nurses from external labour market when the trade unions plan to organize a strike (Kruger, Metzger 2002). The decisions are based on firm assumption that nurses’ work is crucial for hospitals and medical services are impossible without them. The Polish case is different – the practice of hiring external nurses is very rare – due to the cost-saving strategy and to the shortages in the professional workforce on external labour market.

Nurses and midwives are eager to underline the ‘feminine’ character of their trade union, which evades confrontations and demonstrations of power. It is not only the specifics of Polish nurses but also Canadian and American (Armstrong 1993). Their protests are usually organized in shifts, to make it possible to combine them with home and family duties. However the notion of ‘feminine’ is at the same time strongly negotiated. The protests aim to improve status of nurses, which now perceived as low due to the feminization of occupation. The nurses’ aim is therefore to underline to quality and valour of feminized occupation.

Methods of resistance

Ever since the beginning the nurses and midwives organized White Marches. For many of them these demonstrations were the first experiences of political activity and confrontation of their goals with the society. Over the years in 1990s they learned that blocking the streets, roundabouts, pedestrian trespasses and even border crossings were more effective – or more attention catching. Although this form of protest is inconvenient for car drivers, it gives an opportunity of interactions with the citizens and face-to-face discussions about nurses and midwives arguments. Some of the demonstrations ended up in blockades, others as occupations of public buildings. This form was not a common choice among other trade unions. The protesters usually take days off at work or use paid and unpaid holidays. They enter the public building and stay there. Usually the supporting members of the union hand the needed items like sleeping bags or hygiene articles afterwards however it is not always possible. The most publically recognized occupations took place in 1999 when 650 people entered the Ministry of Health and staid there for almost two months (190 persons in the end), the occupation of the Chancellery of Prime Minister in 2007 performed by the trade union president and three main leaders (that resulted in White City action outside the building) and the occupation of viewers gallery in Lower Chamber of Polish Parliament in 2011 by a group of almost 20 trade union leaders and activists, who protested against legitimisation of self-employment in hospitals.

Nurses and midwives present the occupations as necessary act of despair. Their narrations revolve around the emotional difficulty of being away from their families (especially during Christmas), feeling of exclusion and disconnection as the contact with the rest of trade union and relatives is sometimes difficult. The conditions are usually severe and often the occupants sleep on chairs, covered with jackets. The psychological game between the occupants and the political representatives is very tense, based on intensive negotiations held regardless the hour of day and night.

Hunger strikes are recognized in Polish political debate as a non-violence protest (Modzelewski 2000), in cases when nothing else was left. Nurses and midwives followed this tradition of civic resistance and tried to combine it with the rule of minimizing the harm done to the patients. In 2000 during a 6 days protest nurses chose to work and be on hunger strike at the same time. The protesters were exhausted by the intense work and restraining eating. In that case the non-violence protests turned into a form that actually posed a threat to the patients.

Strike

From a legal perspective, strike is a form of protest when the protesters leave their workplaces. However leaving the machines or front desk is different to abandonment of patients' beds. Nurses and midwives try to avoid strikes and instead organized various forms of protests described above. Nevertheless there were cases of regular strikes. During the strikes the work is distributed among doctors and nursing management. Nurses admit that they have to strongly restrain themselves from taking care of the patients.

The abandonment of patients is viewed as controversial decision by the public opinion and nurses and midwives trade union is well aware of that. From the beginning of the protests against the reform, nurses tried to work out a strike scheme, which would enable them to protest properly and to provide care for patients. In effect they came out with a specific form. The striking nurses and midwives gather in one room in the hospital – they come and leave according to their working schedule. Nurse Managers provide the care for patients. Nevertheless, in the “strike room” there is a special telephone with connection to the wards. In case of emergency, some of the striking nurses go to the wards and work. That solution minimizes ethical dilemmas of abandoning the patients. However once again this form of protest is very demanding for nurses themselves; they strike and they work at the same time (and the work is not necessarily paid by the employer). Participation in strike demands great self-mobilization and engagement. Combining strike and work is the ultimate realization of the “no harm to patients” doctrine but it gives additional burden to the striking nurses. It also weakens their bargaining position, as the employer is aware that in case of emergency nurses will work anyway. That strike scheme also encourages employers not to cover any vacancies resulting from strike by hiring external nurses.

White City

In 2007 the Parliament voted an act that guaranteed additional finances for increase in wages for health care sector employees but limited in time. After the demonstration of all health care system employees, the delegation of nurses and midwives decided to stay in Chancellery of Prime Minister as the PM did not want to participate in the negotiations. The several dozens of nurses stayed outside waited all night. They received support – food and warm

beverages from the citizens of Warsaw and in the meantime more nurses came. Within few days the place was fully equipped with tents, canteen, meeting place, while the leaders of nurses and midwives trade union waited for the Prime Minister in the government building, not knowing about the protest in tents (because their mobile phones were stifled). After the threat of hunger strike proposed by the OZZPiP leaders, the government agreed for negotiations on prolonging the act on increase in wages for whole health care sector.

The White City protest, which lasted almost two months in a form of tented camp, was a quite unique experience – for the trade union, for the debate about health care system, for the Warsaw community and the political scene. The nurses cooperated with left wing and feminist groups, which effected in organization of White University (open lectures of scientists, columnists, social activists and artists), White Weekend with free health diagnosis, free newspapers: Bulletin and White Courier were published. The White City became “a place to visit” on Warsaw map. It was the first trade union protest that gathered so much public attention and enthusiasm. As the political situation in Poland was very tense, with much criticism against the government coalition voiced out not only by political opposition but also by mass-media, the White City was a place for opposition to collect political support. It was also the first trade union protest, which received positive media coverage. However it is difficult to estimate if the real goals of nurses and midwives were ever heard. The emotional image of middle aged, hard working and caring women in white caps was confronted with the image of an arrogant government, and it seems that the debate ended, without any deeper consideration about the problems of deregulated system of collective bargaining or the connection between working conditions, the nurse ratio and the quality of care. The White City ended when the government agreed to present new act stating that 40% of the surplus in the contracts between National Health Found and health care units will be dedicated to increase in wages. When the act was introduced it turned out that the nurses and midwives victory was Pyrrhic, as surplus was distributed unevenly and most of the wage increases was focused on doctors. The financial gains of nurses and midwives were almost insignificant and the debate on nurse ratio and quality of care was not continued. In some hospitals nurses and midwives did not receive increase in wages and decided to organize local protests and strikes, which became quite common in 2008 and 2009. However they did not gain any of this positive media coverage that was so characteristic for the White City protest. After the government change (from right wing conservatism to conservative-neoliberals), the nurses’ problems became “yesterday’s news”. Their protests were muffled or presented only briefly, without a broader context of situation in the health care system and implication on the quality of care. The protest in 2011, when trade union leaders occupied the visitor’s gallery in Parliament, protesting against self-employment, did not gather that much media favour, who instead worked very hard to find any self-employed nurses satisfied with their jobs.

Conclusion

The history of nurses and midwives protests raises questions about the tension between the vocation of the occupation, still very much inspired by Florence Nightingale’s ideas, and very militant character of the protests. Nurses are socialized to resign from their interests for the greater good. Their pattern of protests – occupations, hunger strikes, and tent camps include both militancy and very self-sacrifice, which is a high cost. It seems that

– what is not publically appreciated and valued – care work gives them both inspiration and organizational skills. During almost 20 years of protest nurses and midwives managed to disseminate information about their working conditions and the quality of care. Nonetheless it seems that their semi-professional status along with the deep belief in the efficiency of market mechanisms in health care system form severe obstacles. The public appreciation of care work itself and the crucial role of nurse and midwife in the health care system are still goals to achieve.

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Endnote

- 1 The activity and resistance strategies of nurses and midwives were researched in 2009-2010 for the purpose of the Phd thesis. The research had a qualitative character, based on in-depth interviews, documents, media analysis and observation of strikes and protests. The contact with OZZPiP was maintained after the end of the research process.