emecon
Employment and economy in Central and Eastern Europe
emecon.eu

From better job quality to higher-quality care – Polish nurses' collective struggle with the public healthcare system

Julia Kubisa

This article examines Polish nurses' job quality in the context of changes in the Polish healthcare system. Job quality is understood as skill development and workers' participation combined with work quality and employment quality: wage level and type of contract, working time, autonomy, the social work environment and the pace of work. The crucial problems of Polish nurses are connected with lack of control over working time, the forms of contracts, and with increasing work pressure due to low nurse/patient ratios. The specific vulnerabilities of care work are time pressure and work intensification. Its quality relies much on the possibility of teamwork and opportunities to establish a relationship with the patient. The article examines the strategies of collective resistance undertaken by Polish nurses to shape their job quality in relation to its direct consequences for the quality of care.

Key words**:** nurses, job quality, strikes, nurse/ patient ratio, Poland

On 24 May 2016 nurses employed at the Children's Memorial Health Institute (ChMHI), the major paediatric centre for serious illnesses in Poland located in Warsaw, started a strike action and refrained from working. Their basic demands were pay rises and increased staffing of wards. They underscored in this way their exhaustion due to working conditions, such as one nurse per 20 child patients, and low pay that results in the constant need to do overtime. The strike lasting almost three weeks was widely commented in the media and politically debated. Interestingly, though the case conformed to an almost 20-year tradition of nurses' strikes over pay issues in Poland, this time the nurses at the ChMHI managed to point out in their agenda that "job quality" was not only about their wages but that it is a set of interrelated factors – including workloads, working hours and overtime and autonomy that all contribute to the quality of care.

According to statistics presented by the National Chamber of Nurses and Midwives, an obligatory professional organisation, the healthcare system in Poland malfunctions in terms of the provision of nurses' care work. This article aims to examine how this problem is dealt with in the healthcare system in Poland. It presents the decisions and actions undertaken by hospital managements justified by the introduction of flexible employment arrangements, and the reactions of the All-Poland Trade Union of Nurses and Midwives. In this article I examine the changes in Polish healthcare system from the perspective of job quality – understood as the combination of work quality and employment quality – following the model offered by Munoz de Bustillo et al. (2009, 2011). The combined work quality and employment quality approach shows that job quality is a multidimensional phenomenon shaped by the level of wages and type of contract; task discretion; control over working time; autonomy; social support and the meaningfulness of performed work; access to skills development, and participation.

The article aims to map the most crucial problems of this occupational group: job quality, the effects of management strategies and government policies, and the agenda and actions of the trade union, which try to establish the link between job quality and quality of care. The vulnerabilities of care work are time pressure and work intensification. Its quality relies much on the possibility to perform it as teamwork and to establish a relationship with patients. Job quality, understood as a set of work and employment quality arrangements, is prone to

changes initiated by both the employer and employee side. I therefore look at the strategies of resistance undertaken by nurses to shape job quality by showing its direct consequences for the quality of care.

The article is organised as follows: the first part presents methodology, the second presents an overview of changes in the Polish health care system; the third part presents previous research on nurses and job quality, the fourth part is focused on an analysis of the experience of job quality by nurses; the fifth part describes the collective agency of nurses applied to try to influence their job quality by establishing the connection between it and the quality of care, and the sixth part presents the article's conclusions.

Methodology

The article is based on qualitative research comprised of semi-structured interviews, non-participant observation, analysis of the documents, media coverage, and secondary data analysis (see Denzin and Lincoln 2011; Silverman 2013). The main part of the research – 43 interviews and observations – was conducted in 2009 and 2010 for the purpose of a PhD project about the trade union activity of nurses and midwives in Poland, which was initially more oriented towards women's activity patterns in trade unions. The issue of the relation between job quality and quality of care emerged from the research material and brought a new angle to the analysis. In the years 2012–14 the author participated in a research project on the migrations of healthcare-sector workers which made it possible to study the relation between job quality and quality of care further in the form of 10 interviews. The author established a trustful relationship with the nurse community and is in frequent contact with them, which allows her to update the research material. Between 2012 and 2014 the author conducted three press interviews with the union leaders and moderated a debate between union activists, National Chamber of Nurses and Midwives representatives, and head of the nursing department at the Polish Ministry of Health. In 2016 the author moderated two workshops for activists from the All-Poland Trade Union of Nurses and Midwives organised by the F. Ebert Foundation, and held a lecture-debate with nurses (unionised and non-unionised) in western Poland. The meetings, debates and interviews broadened her knowledge and understanding of the tensions between job quality and quality of care as experienced by nurses.

What is job quality?

Generally, there is no single agreed definition of job quality, as it encompasses various dimensions of work and employment. The debates on this phenomenon are mainly carried on in economics, psychology and sociology. It is agreed that the quality of a job is not only about wages, but also about workers' motivation, satisfaction, and well-being, and it can affect productivity. Distinct approaches to the definition of job quality have identified, on the one hand, autonomy and job security as crucial dimensions of a good job (Gallie, 2013), or, on the other, pay and skills (Clark 2005). Many researchers have emphasised other potential components of job quality such as job security, training and development, work organisation, task discretion, employee voice, job satisfaction, working time and work-life balance (Green 2006; Gallie 2007, 2013; Kalleberg 2011). Kallenberg (2011) points out that job quality goes beyond the level of wages (extrinsic reward) because it brings intrinsic rewards – benefits and utilities that people obtain from task performance. Workers who are able to control how and what they do at work (task discretion), according to their skills and knowledge, are more likely to obtain intrinsic reward from their jobs. Therefore job quality is a much more multifaceted phenomenon including the need for interesting, meaningful and challenging tasks over which the worker can exercise responsibility. As Kallenberg (2011) stresses, the loss of control over the pace of work and working time detracts from the quality of the work experience.

The measures of job quality, understood as "a good job" or "decent work", have not been unified. The ILO promotes "Decent Work Indicators" in the framework of the "Decent Work Agenda", which is a combination of four elements: 1-) international labour standards, fundamental principles and rights at the workplace; 2-) employment creation; 3-) social protection and social dialogue; and 4-) tripartism (ILO 2013). The OECD launched its "Job Quality Index", a combination of three elements: earnings quality, labour market security and quality of working environment. ETUI started work on the elaboration of a job quality index after the crisis of 2008 as a response to insufficient indicators of job quality on the European level. The ETUI index is based on a series of sub-indices – wages, non-standard employment, working conditions, working time and work-life balance, training and interest representation (Leschke, Watt, Finn 2012).

The perspective presented by Munoz de Bustillo et al. (2009, 2011) permits a grasp on the multidimensionality of job-quality experience in a comprehensive model. The authors reviewed existing indexes and measures of job quality and the debates in different scientific fields – economics, sociology, psychology, institutional approach, occupational health and safety, and work-life balance studies – in order to sketch a general model of job quality and further develop a "European Job Quality Indicator". This model provides detailed distinctions between various aspects of job quality to facilitate the study of the job experience in selected occupational groups. Munoz de Bustillo et al. suggest analysing job quality by breaking it down into two different areas: *employment quality* and *work quality*. Employment quality comprises elements related to the formal employment relation: wage, type of contract, working hours, distribution of working hours, and social benefits. Work quality on the other hand refers to attributes of the work itself and the working environment, *i.e.* the productive task performed, with the potential impact on the well-being of the workers through [the experience of extremes of temperature, noise, physical effort, speed, work autonomy, and the social work environment. This division into work and employment quality is complemented by elements that belong to both dimensions – access to skill development and participation in decision-making. The model allows the multidimensional study of job quality and tracking of the connections between its elements. At the same time it is a helpful analytical tool to track changes in job quality as an outcome of ongoing negotiations and dynamics between employers and employees with regard to their individual and collective agency.

In this article the job quality experienced by nurses in Poland will be studied along the aspects of the Munoz de Bustillo et al. (2009, 2011) model. Nurses' employment quality is analysed as forms of contracts, working hours and wages, whereas work quality is discussed in terms of work autonomy, physical effort, speed and the social work environment. This then serves as a basis for the discussion of the impact of government changes in the healthcare sector, management decisions and the collective actions of Polish nurses for better job quality.

The healthcare system in Poland

Flexibility and restructuring have often been viewed as a solution for increasing the competiveness of companies. From the private sector the idea was transmitted to the public sector in the form of "New Public Management". The idea behind New Public Management was to introduce market-driven mechanisms in order to make public services more efficient, less expensive, and client-oriented. This market-inspired approach in the public sector focused on achieving outcomes and not on procedures. One of its main elements – along with pressure for effectiveness and individual responsibility (unlike in traditional bureaucracy) – is flexibility in work arrangements, employment and work organisation (Zawicki 2002). The healthcare systems in various European countries have undergone changes under a general framework of "rationalisation" and "economisation" of public expenditures (see Verschuren 1995), which are mainly a result of budgetary cuts. Certain forms of privatisation followed, with private healthcare operators competing for public funding. The rationalisation of hospital

expenditures resembles the "lean production" approach – only here it may be called "lean financing" (Kozek, Radzka 2011). The lean financing approach tries to decrease labour costs, since their share in general hospital expenses is relatively large. Cuts in employment are typically followed by an intensification of work – ostensibly in order to better use the remaining human capital (Buchan, O'May 2002). On the level of practices, this translates into more flexibility of employment arrangements (fixed-term contracts, part-time, various other forms of contracts and self-employment), and the substitution of highly skilled workers by lower-skilled workers who are paid less, as well as hospital restructuring, including the outsourcing of non-medical jobs.

The healthcare sector in Poland experienced turbulence in the 1990s with a decentralisation of healthcare system – tasks and responsibility was transferred to the authority of local governments without proper funding. Due to this the hospitals amassed debts and had to ask patients for private donations or expected them to pay for a part of the medical services (Włodarczyk 1999, Kozek 2006). Access to medical treatment was thereby limited and different categories of workers, including doctors and nurses, experienced significant reductions in wages. The Polish health care system came to be viewed as malfunctioning, with hospitals struggling for a long time thereafter with the problem of constant debts as they tried to provide medical services within insufficient budgets (Kozek 2011). This malfunctioning system underwent a major reform in 1999-2001, which can be interpreted as a flexibility and restructuring paradigm. The introduced changes aimed to resolve these problems through a rapid downsizing of the labour force, whereas in the 2010s the flexibility of contracts with employees was increased and the self-employment of nurses introduced. The reform of 1999 also introduced a financing system based on insurance funds (Włodarczyk 1999, 2010). It aimed to replace government budget financing with contributions collected as taxes. At first there were 17 Health Funds (16 regional and one for military services); after 2003 (and up to today) a single "National Health Fund" contracts medical services and monitors their performance. The National Health Fund does not provide the financing of hospitals, but orders and pays for specific services: medical treatment, operations, and patients' stay in hospitals. The directors (named hospital managers) of hospitals (which were transformed into "independent public health care units") are responsible for the division of the means obtained through the contracts: wages, repairs, and purchases of equipment. This radical change was criticised by trade unions in the healthcare sector. As Jane Hardy, Alice Stenning (Hardy and Stenning 2005, Hardy 2009) and Wieslawa Kozek (2010) point out, this reform was based on the processes of decentralisation, rationalisation and introduction of market mechanisms into public services and institutions, according to the principles of New Public Management for the calculation of the costs of delivery and organisation of health care. The ultimate effect of market mechanisms on the public healthcare system will be its obligatory commercialisation: its transformation into companies, which has been interpreted by some authors as a first step towards the privatisation of hospitals.

The public healthcare system reform included the restructuring of employment. In many hospitals about one-third of workers were laid off (Hardy, Stenning 2005). However, the numbers of patients did not change. Since 2000, when wage negotiations were transferred to the level of the individual healthcare facilities (hospitals, clinics, etc.), the level of wages has depended on various factors: the level of wages on the local labour market, managerial policy (are investments in technology or in human capital?), on the workers' representatives, and on the decisions of hospital nursing departments (Ostrowski 2003, Kubisa 2014).

The market-inspired approach introduced into the healthcare system encouraged head administrators to seek different cost-cutting solutions, including so-called flexible employment arrangements. The freedom of choice between a fulltime employment contract and self-employment in the healthcare sector was confirmed by a set of healthcare Acts voted into law by the Polish Parliament in 2011 and promoted by the government coalition of the Civic Platform party and the Polish People's Party (Trappmann 2011). It is quite common for hospital managers to offer "contracts of mandate" regulated by civil law as a cheaper addition

to regular employment contracts instead of creating new permanent job vacancies. The "contract of mandate" is "a civil law agreement characterised by the freedom to shape the contents of the contract; the lack of a minimum wage requirement; lack of obligation to determine daily and weekly working time limits; the freedom to introduce paid sick leaves and holidays; the freedom to set the time and place of work performance (…). In case the 'contract of mandate' includes too many elements of employment, the contract is converted into an employment contract. It may be terminated at any time (…). The termination takes effect immediately." (Centrum Informacyjne Sluzb Zatrudnienia 2016).

A relatively new phenomenon in the healthcare system is the introduction of nurses' self-employment in place of fulltime jobs. This legal solution was officially confirmed by the set of medical acts passed by Parliament in 2011, in which self-employment was presented by proponents as an example of freedom of choice in the form of employment. It is doubtless beneficial for hospitals as it brings further labour-cost reductions and, managers argue, at the same time potentially higher incomes for the nurses.

Previous research on nurses' job quality

Various aspects of the job quality experienced by nurses have been widely studied. Their work combines long shifts, physical, emotional and intellectual tasks performed as teamwork, and the need to constantly balance the pressures exerted by management and to establish good contact with patients. The aspect of control over place and working time is crucial in healthcare. The work is always unpredictable as there can always be medical emergencies that disrupt planned schedules. Nurses learn early how to cope with the unpredictability of their work time by combining a planned schedule with a large amount of flexibility that allows them to adjust to unexpected tasks. Their working schedules are arranged differently from the "standard" 9-to-5, with frequent night-shifts and 12-hour shifts, and their regular working time is often exceeded by periods of overtime.

Nurses' control over ways of using time at work can be organised differently. The choice to work fulltime, overtime, or less than fulltime, and the relation of this to wages, as well as provisions for time spent outside of work (vacations and sick leave) – all of this has consequences for nurses in terms of valuing and keeping their jobs (Gerstel and Dan Clawson 2014). Nurses value the social environment at work, understood as workplace integration, which together with pay and autonomy are the most important job factors (at least in the case of Norwegian nurses). Also further education, such as one day or more reserved for professional development is a factor positively related to the intent to stay employed at a hospital (Bjørk, Samdal, Hansen, Tørstad, Hamilton 2005). The social environment in nursing work refers to the relation between nurse and patient. Nurses point out that the dialogue between them and patients should evolve towards partnership, both to support the recovery of the patient and to resist the tendency in contemporary health service delivery towards a purely technical form of nursing practice, in order to protect the relational core of professional nursing practice (Jonsdottir, Litchfield, Dexheimer Pharris 2004).

The work quality experienced by nurses is also studied in terms of physical conditions. Their work, especially when not supported by technology, requires assuming strenuous positions and sometimes the lifting of considerable weights. In a recent survey of 100 nurses in Poland, 60 respondents rate their job as physically hard; 28 – very hard; 10 – moderately difficult, and only two evaluate it as physically easy. Seventy-nine think that, over time, their work is becoming more and more difficult physically, with 13 saying that working conditions have not changed over the years, and for eight, it has been getting easier. Asked about equipment for moving patients, 29 say they have it, but 69 do not have such equipment, with two nurses not specifying. The nurses also state they seldom take sick-leave (Wyderka, Niedzielska 2016).

The New Public Management-driven changes impact the working conditions and work intensification of nurses. Selberg (2013) delivers a broad overview of research in the field of changes in Swedish healthcare sector caused by neoliberal pressures. Growing workloads combined with restructuring and organisational changes causes stress, anxiety, burnout and breakdowns at work (Glasberg et al. 2007). Blomgren (1999) underscores that the emphasis on cost-cutting and increased efficiency affects ward nurses' tasks that are the most time-consuming but directly linked to patient care. Selberg's (2013) own research points out the direct connection between the New Public Management-inspired restructuring paradigm and growing workloads, causing both physical and emotional consequences, while the creative altruism embedded in nurses' care work is repressed.

The following section presents outcomes of the research conducted among nurses in Poland, in the context of research on the Polish healthcare sector It focuses on changes in job quality – understood as combination of employment quality and work quality – and on their struggle to improve job quality in the interest of the quality of care they provide.

Nurses and employment quality: wages, forms of contracts and overtime

Nurses represent the largest occupational group in the Polish healthcare system. They are also a highly feminized group. According to the database of the National Chamber of Nurses and Midwives (2015), in 2014 there were 277 334 women and 5188 men certified to work as nurses, 199 188 of whom – according to Poland's Central Statistical Office – were actually working with patients (GUS, 2015). The National Chamber of Nurses and Midwives annually publishes statistics on Polish nurses in European comparison. The number of employed nurses and midwives per one-thousand citizens is 8.1 in the Czech Republic, 7.5 in France, 9.6 in Germany and 9.2 in the United Kingdom. In Poland it is 5.

Low wages has been one of the major problems experienced by nurses in Polish healthcare, creating pressure on them to seek additional jobs. In the early 2000s nurses usually worked additionally as cleaners. Currently, since the number of nurses is decreasing and more retire from than start careers (according to National Chamber of Nurses and Midwives data), additional work within the occupation is increasingly possible part-time. Depending on the local labour market offer, nurses work part-time in at-home care, public and private clinics, and on hospital wards, where intensive teamwork is necessary.

> *My colleagues work on double shifts, and they organise their family lives around that. There are not enough jobs and approximately 20% of nurses are sole breadwinners because their husbands were laid off. So when they have an opportunity to work fulltime and additionally ¾ time, they take it and the husbands take care of the house. Nurses do not have free time; they only have a little time to get some sleep. It was not like that in the past, but now everyone has a second job.* (– nurse and trade union activist, Lublin region)

In one voivodship capital, a new academic hospital employed only three fulltime nurses on its neurosurgery ward. The rest of the nurses worked on contracts of mandate in addition to their fulltime jobs in other hospitals. Hospital managers do not often create new fulltime jobs and do not increase wages, but offer instead additional, fragmentary contract jobs, which enables them to achieve a labour-cost reduction. Head managers do not compete for nurses by increasing wages to attract (e.g.) nurses with rare specialisations.

> *I have a nurse colleague who wants to buy a flat, so she works fulltime as an instrument nurse at the hospital on an 8-hour shift and for the rest of the day and on weekends at a private plastic surgery clinic.* (–nurse working on a hospital ward, Lower Silesia region)

With regard to the contractual conditions in the healthcare sector, the time and place of work performance cannot be freely chosen. As a result nurses work fulltime on a permanent employment contract plus overtime at one location, and additionally work on contracts of mandate at another location or even at the same one. Thus their overall working time is not supervised and they are not discouraged from taking extra hours. On the contrary, with their relatively low regular wages, the overtime and contracts of mandate are regarded as the only solution to improving their home budgets. In 2015 the Polish National Labour Inspectorate conducted a random check of 29 ER wards in the country. In 31% of cases the weekly norm of working time per worker was exceeded; 28% of workers (mostly nurses and paramedics) were not allowed a proper 24-hour rest. There were cases discovered of persons working 14 hours or even 24 hours straight without rest. The National Labour Inspectorate concluded that contracts of mandate very much fostered non-compliance with regulations on working time.

Nursing work on the basis of self-employment as a one-person business means that, in signing a contract with a hospital, nurses are not under the protection of Polish Labour Law provisions, such as working time restrictions. Self-employed nurses are obliged to pay their own social security and tax, and usually they need to hire a book-keeper to do their accounting. The self-employed social security contribution, as for all self-employed, is a low flat-rate, which poses a threat to their future retirement income level. Self-employed are not entitled formally to paid holiday, and their sick leave is less beneficial compared to that of those on full employment contracts.

> *I am on a 24-hour shift – that makes about 10-11 shifts per month. I sleep between the shifts: we have a bed in the office for taking naps there. Because of the service contracts we now have more staffing on the wards.* (–self-employed nurse, Silesia region)

Although nurse self-employment is practiced 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 many more hours than the Labour Law regulations permit, sleeping between work shifts in staff rooms. There are no state regulations that limit their work time or monitor whether they take holidays. According to Polish trade union law, the self-employed cannot be organised by trade unions, so that the cost-cutting strategy is, as well, an anti-union strategy.

Nurses' work quality: work intensification, autonomy and social work environment

The work performed by nurses is a multidimensional combination of high-level skills, dirty work (Wolkowitz 2006) and emotional labour (Hochschild 2012). They perform physical work, deal with high levels of stress and critical situations, and all the while are responsible for the administration of medicines.

The major issue that has been raised by Polish nurses is the rapid decrease in staffing levels on wards. The nurses have attempted to publicise the issue of nurse/patient ratios, which is regulated by official minimum staffing standards on wards. This problem has been recognised internationally. As Susan Gordon, John Buchanan and Tanya Bretherton (2008) write, the debate over the suitable number of patients per nurse is the direct result of healthcare system reforms of the 1990s. The strategy of cost-cutting came to be focused on nurses, who were assessed as being a too-numerous group of employees. The resulting work intensification for nurses was accompanied by the systematic shortening of time spent at hospital by patients.

> *Our colleagues work one nurse per 40 patients; sometimes they are alone on the ward on night shift and the ward is located on two floors. We have been fighting for new regulations because a nurse should not be responsible for 40 patients at the*

same time. But as it is now, she is fully responsible for them. (–trade union leader, regional level)

Intensification of work, jointly with a lack of material possibilities for good-quality care, results in high frustration levels among nurses, out of anxiety that they cannot take care of their patients properly. In Poland the cuts in fulltime nurse employment and low nurse/patient ratio is resulting in even more dangerous situations for patients, with one nurse often responsible for 20 to 30 patients. In the case of long-term care, one nurse is often alone on a ward on the night shift.

There have been several attempts to regulate the nurse/patient ratio. In 1999 the Polish Minister of Health introduced a mechanism for calculating an appropriate ratio. It was a complicated algorithm that assumed six months' observation of nurses' work, personnel rotation and patients' densities. According to nurses it was very difficult to conduct observations of conditions of work intensity without an IT program to facilitate the task. In 2012, after a very long process of consultations with the National Chamber of Nurses and Midwives and the All-Poland Trade Union of Nurses and Midwives, the Ministry of Health proposed new scheme, which was supposed be based on proposals made by both nurses' organisations. Nonetheless, the Ministry's proposal does not solve the basic problem of determining the minimum number of nurses on wards. The regulation currently in force transfers the responsibility for defining the adequate number of nurses to the head manager of the hospital. Therefore in each case the ratio can be different and is actually dependent on the hospital's budget. What is more, another key aspect lies in the norms included in the contracts offered by the National Health Fund. In the case of doctors, the NHF requires a certain obligatory number of different specialists. However there is no required minimum of nurses. The NHF offers general nursing fulltime contracts without any indication of the share of those contracts in the different categories of the hospital budget. Therefore it is up to hospital managers to decide whether they will invest more in technology or in human capital – and, in the latter case, in which occupational groups.

Our input into the realisation of the contracts with the National Health Fund is really significant. But there is no discussion here. Work with machines should not be worth more than work with a human: what is more important – the skill needed to press a button, or to work with a sick person who is in deep crisis? Here in Poland it is always the technicians who are more important because they work with precious machines. But it is the nurse who supports the patient in getting back to health and life. (–nurse on a hospital ward, trade unionist)

As nurses often point out, the valuation of job importance in hospitals is crucial, with workers' responsibilities in diagnostic technologies usually being valued higher than nurses' care work. There is consequently relatively more investment in medical technologies than in care technologies that support nurses' work (e.g. man lifts, levers, rotators).

In 2015 the All-Poland Trade Union of Nurses and Midwives conducted a survey among working nurses and midwives about their experience of working conditions. The problem of nurse staffing and the aging of this occupational group is widely acknowledged among nurses. They point out that there is a clear connection between these issues and the excessive intensification of work. Another relatively common problem related to the deficits in staffing and budgets are one-person shifts. Twenty-five per cent of nurses and midwives interviewed had worked such shifts in the last three months, and among them, most had worked such shifts more than once per week. In hospitals, almost one-third of nurses had worked one-person shifts, and more often than once per week. Almost 95% of respondents claim that they cannot fulfil all their work duties on their shifts due to extra tasks that are actually not in their job description, e.g. filling out medical documentation (21%), managing the flow of medical items (21%), writing reports of routine medical examinations, writing out doctors' prescriptions (14%), transport of patients between wards (13%), cleaning (10%), medical registration (9%) and monitoring the performance of doctors (7%). Generally nurses and midwives say they have too much bureaucratic work that keeps them away from patients.

The lack of control over the pace of work and increasing intensification of work results in very low work autonomy. As nurses are overloaded with tasks, their influence over the scope of their responsibilities is less. They may also lose control over the procedure of distribution of medicines (formally, one nurse should be responsible for the preparation and distribution of medicines). In reality, due to work overload, one nurse prepares medicines and another who is available administers them to the patients, which creates many opportunities for mistakes.

Nurses are trained to work in teams – with other nurses, technicians, doctors and cleaners. The traditional hierarchical system, still visible in Polish hospitals, frames nurses into a "feminised servant group", and this along with low staffing rates results in the deterioration of the nurses' social work environment because they find it difficult to find social support within the workplace. What is equally important, they do not have time to establish proper contact with patients and their families; for example, they lack time to pass on information to patients about proper diet and healthy lifestyle that are important parts of the process of regaining health.

Strategies and problems of collective action

Nurses and midwives have attempted to counteract the unwelcome changes in the healthcare system by introducing their point of view and experience into the public debate. The most-recognised worker representation organisation is the All-Poland Trade Union of Nurses and Midwives (OZZPiP) with 20 years of activity history. All workers in the healthcare sector face the dilemma of choosing a form of protest that will not harm patients and yet are visible. The union seeks to form a model of resistance that can publicise members' problems and demands without posing any risk to patients. They argue that there is a strong link between *job quality* – nurses' working conditions, contracts and wages, and the level of *quality of care* for patients. The nurses' protests have very much underscored the connection between the character of needed reforms and their ability to offer best-quality care to patients. This may be interpreted as a process of "occupational socialisation". As Rebecca Priegert Coulter (1993) writes, nurses are trained in a holistic and individualised approach to care work. This approach stands in opposition to transformations in healthcare systems imposed by the pressure to economise services. The strikes and protests by nurses in Poland are therefore similar to nurses' reactions to changes in healthcare systems in many other countries. Briskin (2013:120) sums up this as the "politisation of caring: a recognition of the collective responsibility for caring, and the impact of deteriorating conditions of nursing work on quality care; the rejection of essentialist claims that women are responsible for caring work by virtue of being women; the demand that the skills involved in caring work be recognized and rewarded; and the willingness to mobilize collectively to these ends."

The OZZPiP's agenda is focused on a new vision of a healthcare system that provides good quality care and opposes the "race to the bottom". OZZPiP has tried to take up the "politisation of care" approach (Briskin 2013) that can alert public opinion about the worsening job quality that in turn affects the quality of care. However, the decision to organise a widely visible protest or strike is usually difficult because nurses want to avoid any harm thereby to patients. Their main rule therefore has been to organise protests, which will have minimal negative impacts on patients and the routine activity of hospitals – quite a paradoxical assumption for a workers' protest in the form of a work-stoppage. In terms of protest, over the last 20 years nurses have organised demonstrations, blockades of streets and border crossings; they have become known for occupying public buildings such as Ministries, the Prime Minister's Office and visitors' gallery in the Polish Parliament, as well as for organising "protest camps" in front of public administration buildings, with the 2007 "White Village" the most prominent among these. They often use the method of the hunger strike, while trying to minimise the risk of any harm to patients. During a six-day protest in 2000, nurses chose to work and be on hunger strike at the same time. The protesters were exhausted

by the intense work and the lack of meals. This non-violent protest turned into a form of action that conceivably may have posed a certain threat to the well-being of hospital patients (Kubisa 2014).

> *We always left the head ward nurse, we organised an ER team and on the hour, two of us went through the wards to check the patients and the number of doctors. If anything serious happened, they called us on the phone and we immediately went to the wards.* (–nurse, trade union leader, regional level)

During strikes the work is provisionally distributed among doctors and nursing management. Nurses admit that they have had to strongly restrain themselves from taking care of patients. Therefore during a strike they usually create a strike method that enables them to participate in the protest and take care of their patients at the same time. The nurses gather in one room and refrain from performing work. However in case of emergency they answer the call and take up tasks on their wards. Combining striking and working effectively is the ultimate realisation of the "no harm to patients" doctrine, but it places an additional burden on the striking nurses. It also weakens their bargaining position, as the employer is aware that in case of emergency nurses will work anyway. The strike scheme described also discourages employers from covering any vacancies resulting from a strike by hiring external nurses.

The decentralised model of the healthcare system has in the past hindered coordination of collective protests that could put pressure for change on the Ministry of Health (and not only on the heads of hospitals). This changed in 2015 when trade union leaders managed to convince shopfloor leaders to coordinate their activities in order to enter into collective disputes with the hospitals all at the same time. This level of coordination would enable them to launch a general strike of nurses in hospitals all over Poland. Meanwhile the leader of the trade union, in collaboration with the leaders of the National Chamber of Nurses and Midwives, continued talks with the Ministry of Health, negotiating for a stabile mechanism of wage increases to be built into the financing system and independent of the individual decisions of hospital managers. In early autumn of 2015, one month before parliamentary elections, nurses organised massive demonstrations in Warsaw and threatened a general strike. After intense negotiations, the Ministry signed an agreement called "4 x 400" that guaranteed nurses wage increases to be introduced in four parts over four years. Each year wages would increase by 400 PLN gross (approx. 100 euros with tax) per month from a special fund created by the Ministry to be transferred to National Health Fund. However, the same agreement limits nurses' protest activities – they are prohibited from organising similar coordinated protests at the national level. The wage increase after tax is 230 PLN (approx. 50 euros) monthly. The money was to be distributed among nurses who work on fulltime employment contracts as well as other forms of contracts. Nevertheless, the problem of understaffing of nurses that causes work-related stress and pressure and endangers patients was not addressed. This is clearly seen in the case of Children's Memorial Health Institute where nurses earn little – even with the additional 230 PLN – and suffer dire working conditions due to understaffing.

Conclusion: job quality and care quality – still at an impasse?

The outcomes of union activity, despite its having shown the crucial relation between changes in job quality and of care quality, are ambiguous. Over the last several years the union has managed to initiate the discourse of job quality, resulting in public awareness of the nurse/patient ratio problem that translates into higher work intensity and in the end prevents the optimal performance of care work. However, union bargaining achievements in terms of wage raises never reached a point that would allow nurses to stop taking extra jobs in healthcare, although in 2015 the first built-in, regular and independently funded wage

increases were achieved. However, the real change in wages will be experienced only in 2020 when the "4 x 400" will be fully achieved.

Nor did this development stop the self-employment of nurses. The Civic Platform party and Polish People's Party coalition government represented self-employment in terms of the freedom of choice over the form of contract and prioritised this higher than risk of the potential harm to the performance of care work. The flexibility discourse prevailed over that of the value of care. The employers' and the government's perspective fragments job quality into its aspects and detaches the issues of contracts and wages from those of work intensification and task discretion. Flexible employment arrangements dressed up as "freedom of choice" are simply more attractive than cost-cutting explanations.

The nurses have at least learned to act collectively as a trade union in order to show together job-quality aspects and the influence of changes that are deteriorating care quality. They may still not have any control over working time and shifts and therefore hardly enjoy any autonomy or control over the pace of work due to work overload. Their low wages create pressure on them to take on extra work often far beyond the amount of a fulltime job. The legal arrangements in the healthcare sector make it possible to use other so-called flexible forms of contracts regulated by civil law (instead of labour law), or as self-employment. The working time regulations of labour law do not apply to these contracts and therefore the extent of working time is set only between the contract parties. The employees' position is thereby significantly weaker since they lose the possibility to influence the extent of flexibility. This disadvantage is made worse by deficiencies in the legal procedures: the fact that contracts with the National Health Fund do not stipulate the minimum staffing of wards with nurses, nor regulate the use of non-labour law types of contracts.

Although the appearance of the new forms of contracts and work intensification bring savings to hospital budgets, they strongly affect the quality of care work, which may turn out to be more expensive for the health care sector in the long run. Low staff levels on wards increases the possibility of mistakes by nurses and in the end is potentially dangerous for the health and life of patients. The same applies to higher work pressures and the lack of control over working time of self-employed nurses. Theoretically they should enjoy more control over time and the pace of work, but in practice they work much more than in a regular fulltime job; the chronic fatigue they suffer again increases the risk of serious mistakes.

Paradoxically, though the cost-cutting approach combined with a short-term employment perspective has produced a situation of too few nurses, the critical point has not been reached. Meanwhile the quality of care is still affected by decreasing job quality of nurses. Low wages still push nurses into taking on extra work, which remains the most dangerous factor – much more than any strike that keeps some of the protesting nurses away from patients.

Post scriptum

In the parliamentary election campaign of late 2015 that brought the right-wing "Law and Justice" party a majority in the parliament, politicians overtly promised that they would solve the problems of nurses and reverse the commercialisation mechanisms that had appeared in the healthcare system. However, thus far the actions of the Health Minister have not been oriented towards recognition of the relation between job quality and care quality. His reaction to the strike at ChMHI was very confrontational and hostile towards the protesting nurses. His only proposed solution to solve the problem of understaffing has been to decrease the educational standards of nurses. Currently they are obliged to have a university degree, while the Minister suggests secondary education should alone be sufficient. This is supposed to make nursing "more accessible", but in reality it would only block nurses' access to all European healthcare labour markets and hinder the migration of young nurses. Even though the approach of the Minister of Health is not NPM-inspired, it is still not focused on the job quality of nurses or on the quality of their care work. So far it can be characterised only as disciplinary and punitive, as there have been no visible attempts to improve working

conditions that would make nursing an interesting and attractive job. This turn, in politics and policy terms, will probably result in new waves of activity by nurses pushing for the recognition of the value of their care work and the consequent improvement of their job quality.

References

Bjørk I.T., Samdal G.B., Hansen B.S., Tørstad S., Hamilton G.A. (2007). Job satisfaction in a Norwegian population of nurses: A questionnaire survey. *International Journal of Nursing Studies* 44 (2007) 747–757

Blomgren, M. (2003) 'Ordering a Profession: Swedish Nurses Encounter New Public Management Reforms', *Financial Accountability & Management* 19(1): 45–71.

Briskin L (2013) Nurse Militancy and Strike Action. *Workers of the World – International Journal on Strikes and Social Conflicts* 1(2): 105–134.

Buchan J., O'May F. (2002). The Changing Hospital Workforce in Europe. In McKee M., Healy J. (eds) *Hospitals in Changing Europe.* Open University Press, Buckingham, Philadelphia.

Centrum Informacyjne Sluzb Zatrudnienia (2016) http://zielonalinia.gov.pl/web/zielona-linia (accessed 18.07.2016)

Denzin N., Lincoln Y. (2011) *The Sage Handbook of Qualitative Research.* Sage Publications.

Gallie, D. (Ed.). (2013). *Economic crisis, quality of work, and social integration: the European experience*. Oxford University Press.

Gallie D. (2007) (eds) *Employment Regimes and the Quality of Work.* Oxford: Oxford University Press.

Gerstel N. and D. Clawson (2014) 'Class Advantage and the Gender Divide: Flexibility on the Job and at Home' in *American Journal of Sociology*, Vol. 120, No. 2 (September 2014), pp. 395-431.

Glasberg, A., A. Norberg & A. Söderberg (2007) 'Sources of Burnout among Healthcare Employees as Perceived by Managers', *Journal of Advanced Nursing* 60(1): 10–19.

Gordon S. (2006). *Nursing Against the Odds: How Health Care Cost Cutting, Media Stereotypes, And Medical Hubris Undermine Nurses And Patient Care (The Culture and Politics of Health Care Work)* Ithaca/London: ILR Press.

Gordon S., Buchanan J., Bretherton T. (2008). *Safety in Numbers. Nurse – to – patient Ratios and the Future of Health Care* Ithaca/London: ILR Press.

GUS Główny Urząd Statystyczny (2015) *Statistical Yearbook of the Republic of Poland 2015.*

Hardy J. (2009). *Poland's New Capitalism.* London: Pluto Press

Hardy J., Stenning A. (2005). Public Sector Reform and Women's Work in Poland: 'Working for Juice, Coffee and Cheap Cosmetics! In: *Gender, Work and Organization* vol. 12 issue 6.

Hochschild Arlie (2012). *The Managed Heart. Commercialization of Human Feeling.* University of California Press; 3 edition.

International Labour Organization (2013) *Decent Work Indicators. Guidelines for producers and users of statistical and legal framework indicators.*

Jonsdottir H., Litchfield M., Dexheimer Pharris M. (2004) The relational core of nursing practice as partnership. *Journal of Advanced Nursing*, 47(3), 241–250

Kalleberg, A (2011) *Good jobs, Bad jobs: The rise of Polarized and precarious employment systems in the United States, 1970 to 2000s*, New York: Russell Sage Foundations.

Kozek W. (eds.) (2011). *Gra o jutro usług publicznych w Polsce.* Warsaw: Wydawnictwa Uniwersytetu Warszawskiego

Kozek W., Radzka B. (2011). Wpływ liberalizacji i prywatyzacji usług publicznych na zatrudnienie. In Kozek W. (eds) *Gra o jutro usług publicznych w Polsce.* Warsaw: Wydawnictwa Uniwersytetu Warszawskiego.

Kubisa J (2014) *Bunt białych czepków. Analiza działalności związkowej pielęgniarek i położnych.* Warsaw: Wydawnictwo Naukowe Scholar.

Munoz de Bustillo, R. M., Fernández-Macías, E., Esteve, F., & Antón, J. I. (2011). E pluribus unum? A critical survey of job quality indicators. *Socio-Economic Review*,

Munoz de Bustillo, R. M., Fernández-Macías, E., Esteve, F., & Antón, J. I. (2009). Indicators of Job Quality in the European Union. Employment and Social Affairs. European Parliament.

Ostrowski P. (2003). Deregulacja rynkowa w procesie reformy ochrony zdrowia a protesty pielęgniarek i położnych. In: Kozek W. (ed.) *Instytucjonalizacja stosunków pracy w Polsce* Warszawa: Wydawnictwo Naukowe Scholar.

Leschke J., Watt A., and Finn M. (2012) *Job quality in the crisis – an update of the Job Quality Index (JQI).* European Trade Union Institute. Brussels.

Priegert Coulter R. (1993). Alberta nurses and the „illegal" strike of 1988, in: L. Briskin, P. McDermott (red.), *Women Challenging Unions*. Toronto: University of Toronto Press.

Selberg R. (2013) Nursing in Times of Neoliberal Change: An Ethnographic Study of Nurses' Experiences of Work Intensification. In *Nordic Journal of Working Life Studies.* Vol. 3 No2.

Silverman D. (2013) *Doing Qualitative Research.* Sage Publications.

Trappmann, V. (2011) Precarious employment in Poland – a legacy of transition or an effect of European integration?. *Employment and economy in Central and Eastern Europe, emecon* 1/2011.

Verschuren R., de Groot B., Nossent S. (1995). *Working conditions in hospitals in the European Union.* European Foundation for the Improvement of Living and Working Conditions. Dublin.

Włodarczyk C. (2010) *Wprowadzenie do polityki zdrowotnej.* Wolters Kluwer Warszawa.

Włodarczyk C. (1999). Reforma opieki zdrowotnej. In: L. Kolarska – Bobińska (red.) *Druga fala polskich reform.* Warszawa: Instytut Spraw Publicznych.

Wolkowitz C. (2006). *Bodies at Work*, London: Sage.

Wyderka M.I., Niedzielska T. (2016). Ergonomics in nurse' work. *Pielegniarstwo polskie.* Nr 2 (60) 2016.

Zawicki M., (2002) New Public Management i Public Governance – zarys koncepcji zarządzania publicznego, in *Studia z zakresu zarządzania publicznego*, red. J. Hauser, M. Kukiełka, Wydawnictwo AE, Kraków