Working Conditions and Health Care in a "Recuperated" Clinic in Cordoba, Argentina

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Abstract

Argentinean economic reforms introduced in the 1990s were characterized by structural adjustments which increased both job insecurity and barriers to health care. In Córdoba, some individuals found themselves without health coverage. Conversely, many private practices, also in crisis, were forced to close with a resultant loss of heath care jobs.

Rather than accepting layoffs, the employees of the private Junin Clinic took over the facility and reorganized it as a cooperative. They wanted both to keep their jobs and to provide affordable health services primarily to the uninsured. We hypothesized that the quality of their clinical jobs would impact on the care they provided.

We undertook to examine how changes in the organization of the clinic affected working relations and working conditions . We undertook a descriptive, correlative survey of 25 employees chosen via a multi-stage process to be representative of the clinic.

Four percent worked under contract; eighty percent were professionals who split their earning 50/50 with the cooperative. The remaining workers were cooperative members.

Fifty percent of those interviewed earned less than the basic minimum wage. Forty-four percent worked alone; the remaining workers were part of teams. Eighty-eight percent felt that their job was appropriate for their level of training. No one reported any occupational accidents. Eighty percent reported satisfactory hygienic conditions in their workplace.

While the division of labor at the clinic had not changed since the take over, administrative structures were different. Cooperative decisions are made in large meetings. Since most professionals are not members of the cooperative, they do not participate in these meetings. However, we observed that relations and exchanges among the workers were less hierarchical.

This work was undertaken to inform the debate on the relationship between working conditions and the provision of health care. We found that the work environment impacts on health care workers as they try to provide a more equitable form of health care.

Introduction

Following a coup in 1955, the *de facto* military government implemented an economy recovery program called the Prebisch Plan; this plan was designed by economist Raul Prébisch and implemented in 1956. By manipulating economic data, Prébich was able to argue that Argentina was facing the greatest economic crisis of its history. Recovery would come only from good fiscal policies ("sound money") which would reduce public sector employment, "rationalize" state-owned enterprises, and reduce government spending (Rapoport, 2007). Cuts in public health spending went hand in hand with policies that strengthened the private health sector. Private clinics and hospitals were imposed as the optimal model for health care. (Belmartino, 2000)

Structural economic reforms of the 1990's furthered these changes in the role of the state with respect to health. Structural adjustment policies led to workforce "rationalization," closure of "surplus"

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services, and billing by public hospitals for services provided to members of the Social Security System (OS, Obras Sociales).

In practice workforce "rationalization" not only meant drastic staff reductions; it also introduced new payment mechanisms based on incentives and staff training.

These policies also affected the private sector, deepening job insecurity and instability. In Córdoba, between 2002 and 2004, the private sector lost about 350 beds principally through the closure or downsizing of institutions. The impact of these closures was felt in the public sector. By 2004 all major public facilities were operating at full capacity. The result was shortened hospital stays, turning away of patients in need, and postponement of scheduled surgeries (La Voz del Interior, 27/06-/2004).

The economic crisis of the 1990's also meant that the Social Security system saw sharp declines in its income due to declining wages, high unemployment, and job insecurity.[1] This left an important sector of the population without health care coverage. Data from INDEC show that in 2005 41.1% of the country's population were not covered by Social Security or a medical or group plan. In 2009, 40% of the population were in the same situation (Abeledo, 2009).

Junin Clinic Health Cooperative

The 2001 economic crisis left the Junin Clinic unable to cover the costs of salaries and forced to gradually close down services. The workers' situation had been deteriorating since 2000. Social Security contributions were being not made, overtime hours were no longer recognized, and wages were paid in installments. In a context where unemployment had reached historical highs, workers had been forced to accept these conditions.

In early 2002 the inpatient service and clinics were closed, and almost all medical personnel lost their work. Those workers who remained began to mobilize in face of the imminent closure of the clinic. The union did not support this effort. However, very quickly broad sectors of society—including revolutionary parties, social movements, and neighbors of the Clinic—came out in support of the workers, who were demanding payment of back wages and a reopening of the clinical services.

In this process, 36 workers (nurses, janitors / maintenance staff, administrators, and one doctor) occupied the building and made contact with workers from other recuperated enterprises. After receiving no response from the owners of the Clinic, the workers decided to reopen the facility on June 13th and to provide primary care charging only a "solidarity bond." Health professionals provided free services to the occupying workers.

The occupiers demanded that the clinic be nationalized and put under the control of the workers. The government, however, seemed uninterested. After reviewing the state of Argentinean public health policy, the workers opted to form a cooperative rather than seek nationalization. Professionals were not permitted to be members of the cooperative; rather they split their earnings 50/50 with the workers.

To protect themselves from eviction it was necessary to resolve the legal ownership of the clinic. The workers presented a draft law expropriating the clinic for reasons of public utility. The clinic would become property of either the city or province who would, in turn, hand it over to the cooperative. This law passed in March 2005 and the city gave the clinic to the cooperative for a period of two years during which the workers were supposed to come up with the money to buy the building. This was obviously an impossible task to accomplish in such a short period of time.

Thus, when the two years passed, the workers were once again facing eviction. They renewed their protests and forced the provincial legislature to pass yet another temporary expropriation law. Like the first, the workers were given two years to indemnify the former owners. Failing that, they would again find themselves subject to eviction two years down the line. The uncertainty created by this situation led the clinic to limit itself to primary care services.

Finally, in December 2008, the Provincial Legislature passed a final expropriation law and committed itself to finding funds to compensate the owners. In return the cooperative had to pay back the province by providing medical services.

By the end of 2009 the workers had made necessary improvements in order to rehabilitate the clinic's physical plant. However, they still do not therapeutic services and a part of the building re-

[1]Job insecurity refers to insecure work which does not guarantee conditions sufficient for a dignified life. Insecure work is characterized by outsourcing, contract labor, internships, informality and illegal shops. Its methods include low wages, the threat of firing, and the lack of benefits and social security.

mains idle at present.

Currently, the clinic serves over 4,500 users a month. They are members of a heath plan designed for people excluded from the Social Security system. Among the benefits are access to medical care 24 hours a day, nursing care, outpatient medical services, physiotherapy, psychology, addiction treatment, dentistry, laboratory testing, X-ray, ultrasound, Doppler, surgical services, speech therapy, and nutrition counseling.

Decisions regarding the management of the Cooperative are made in large monthly meetings of all members. Professional employees can attend these meetings if they make a request; they cannot vote.

The Cooperative is formally governed by an Administrative Council. However, the members—via the General Assembly—are recognized as the final authority on all decisions. Management decisions are made by the General Assembly and the Council is then charged with implementing them.

The Cooperative has more than 90 workers of whom 22 are members. Seventy professionals provide outpatient services in various specialties: dermatology, gynecology, urology, pediatrics, endocrinology, general surgery and proctology, vascular surgery, plastic surgery, cardiology, orthopedics, gastroenterology, neurology, electroencephalography, ophthalmology, ENT, hematology, oncology, allergic diseases, nephrology, infectious diseases, psychiatry, psychology, radiology and laboratory services. The clinic also participates in "Operation Miracle" an international program in which Cuban doctors perform free ocular surgeries.

The recuperation of the clinic developed in response to the closure of the company and was a defensive response by workers faced with losing their jobs. However, as the cooperative evolved, the workers became concerned not just with the right to work, but also with the right to health.

The members of the cooperative have worked to safeguard these rights and to minimize the hierarchical structures characteristic of the health care system. However, there has not been a critical reflection on how working conditions impact on the provision of health care. We undertook this study to examine working conditions and working relations in the cooperative. Our study addressed the following issues:

1. Working conditions.
2. Work organization
3. Relations among staff
4. Impact of work relationships and conditions on workers' lives outside of the clinic
5. Impact of work relations and conditions on the care provided to users.

Methodology

This article is part of a multi-disciplinary research project: "The structure of work in Argentina (workers' survey), National University of Cordoba." Research on the Junín clinic began in 2007.

The research process began with direct observation of the general meetings of the cooperative. In order to foster broad-based solidarity with their demand for expropriation of the clinic, cooperative members invited guests to attend these meetings; these included militants, students, and workers from diverse social sectors. These meetings took place between April and May 2007.

In 2008 we made several visits to Clinic. We toured the building with members of the cooperative who explained the operations of each unit. We also conducted direct observation and interviews in the waiting room with patients and professionals working for the Cooperative.

In November and December 2008 we participated in the Cooperative's general meetings. At that time the Cooperative was again calling for a broad movement to support expropriation of the Clinic.

These initial observations led to a second phase of research during which we evaluated working conditions at the clinic and their impact on the care provided. We used a 66 question survey covering: demographic information on the respondent, working conditions, labor relations, and the impact of working conditions and labor relations on the lives and health of the workers. Between February and March 2009, we administered surveys to 25 of the clinic's 97 employees.

Interviewees were picked from the Cooperative's master employee list which was provided to us by the President of the Cooperative in November 2008. The list indentified the service in which the employee worked as well as the post. We picked every third employee in each service to interview beginning with the first. In other words, we interviewed the first, fourth and eighth employees (and so on). If there were less than three employees in a service, we interviewed the first. The Cooperative's Administrative Council approved the study, and all invited workers participated voluntarily.

The surveys were conducted in the workplace at a time that was agreed upon in advance. Survey administration lasted between 35 and 60 minutes and surveys were administered by the researchers. The length varied depending on the degree of em-

pathy achieved with the interviewer and the willingness of the respondent to provide more detailed information. The surveys were conducted over a period of 40 days; this time allowed the researchers to collect general information about clinic, make their own observations about the clinic and its units with respect to work environment, and the relations between different units and the public. Notes were taken daily. Only one case interviewee (a professional) was reluctant to participate in the survey which had to be rescheduled three times because of too much other work. In general, interviewees seemed willing to participate and the fieldwork went smoothly.

If an interviewee was unable to make an appointment due to unforeseen circumstances, the interview was rescheduled at a later day during the week. This problem occurred primarily with the professionals. On four occasions it was necessary to postpone interviews because of unusually heavy user demand when they were on-call.

Eighty per cent of the sample were professionals; four per cent were contracted maintenance personnel, and sixteen per cent were Cooperative members; Cooperative members worked both in the management of the clinic as well as in maintenance, administration and nursing.

This article presents the results of the second phase of our research, primarily the survey data. We also present some of our observations as these provided information about topics which could not be addressed in the survey.

Results

Results of the survey are presented in tabular form on this and the following pages.

Working conditions

Professionals who work at the Cooperative receive fifty percent of the cost of their services; the rest goes to the Cooperative. The members of the Cooperative are paid from the Cooperative's earnings. After deductions to cover maintenance costs and payments to the salaried workers, any surplus is distributed equally among Cooperative members.

More than half of the respondents reported earning less than the minimum wage ($ 1,240). Only one respondent earned more than the minimum. Respondents explained their low income by lack of demand. Nearly two thirds supplemented their income with other work. Only a third reported that

	N	%	Σ
Can you save part of your income?			
Yes	2	8	8
Sometimes	7	28	36
No	16	64	100
Do you think more personnel needed in the area where you work?			
Yes	8	32	32
No	17	68	100
Do you feel your job is insecure or do you worry you will lose it?			
Never	9	36	36
Rarely	8	32	68
Frequently	6	34	92
Very Frequently	2	8	100
What bothers you about your job?			
Nothing	8	32	32
Inadequate salary	9	36	68
Denial of labor rights	1	4	72
Usurpation of my work or creativity	1	4	76
Lack of resources or materials	3	12	88
Lack of patients	2	8	96
Economic limitations on]professional development	1	4	100
What about your job keeps you from doing what is right for patients?			
Lack of knowledge or practice	1	4	4
Lack of equipment or resources	9	36	40
Fatigue / Feeling wiped out	4	16	56
Avoidance of certain patients or conflicts	1	4	60
Conflicts with co-workers	3	12	72
No barriers	6	24	96
Not enough work	1	1	100

		Health Professional (20)	Cooperative Member (4)	Main-tenance (1)	Total (25)
Monthly Income	< 1000	10	1	1	12
	1001-1500	7	3	0	10
	1501-2000	1	0	0	1
	No Response	1	0	0	1
Do you have another job?	Yes	16	0	0	16
	No, but looking for one	2	2	1	5
	No & not looking for one	2	2	0	4
How many hours do you work each week?	20 or less	2	0	0	2
	21-35	6	3	1	10
	36-45	3	0	0	3
	More than 45	9	1	0	10
Working Hours	Fixed days & hours	19	3	1	23
	Rotating Shifts	1	1	0	2
Have service needs impacted on your labor rights?	Never	19	3	1	23
	Occasionally	1	1	0	2
Does your workplace meet mini-mum standards of safety & hy-giene?	Yes	15	4	1	20
	No	5	0	0	5
How do you usually work?	Alone	10	0	1	11
	Alone & in a team	10	4	0	14
Is there opportunity in your workplace to discuss and reflect on your daily activities and the flow of work with your col-leagues or superiors?	Yes	7	3	1	11
	Sometimes	3	0	0	3
	No	10	1	0	11
Is your level of skill recognized in your job?	Yes	18	3	1	22
	No	2	1	0	3
Are you bothered by mistreat-ment, abuse, disrespect or other workplace conflicts?	Never	18	2	1	21
	Rarely	2	2	0	4
Does your work rewarding to you?	Every Day	19	4	1	24
	A few times a week	1	0	0	1

		Health Professional (20)	Cooperative Member (4)	Main-tenance (1)	Total (25)
How do you rate the authorities in the clinic?	Good	14	3	1	18
	Average	3	1	0	4
	There are no authorities. We work as a team	2	0	0	2
Do you see your interests as a worker as being the same as those who run the Clinic? Why?	Yes, our objectives are the same	7	1	1	9
	Yes, because this is a cooperative	7	2	0	9
	Yes, because there is no competition	0	1	0	1
	Yes, because authority is shared.	1	0	0	1
Are emotional problems at work managed appropriately?	On a daily basis	12	2	1	15
	A few times a week	1	0	0	1
	A few times a month	2	1	0	3
	Never	5	1	0	6
When your work day is over are you exhausted?	Every Day	4	1	0	5
	A few times a week	4	2	0	6
	A few times a month	2	0	0	2
	Never	10	1	1	12
When you get up in the morning and prepare for another day at work do you feel exhausted?	Every day	3	1	0	4
	A few times a week	2	1	1	4
	A few times a month	3	0	0	3
	Never	12	2	0	14
Do you feel your job hardens you to other people?	Every day	7	2	0	9
	A few times a month	1	0	0	1
	Never	12	2	1	15
Does your job harden you emotionally?	Never	15	2	1	18
	Every day	5	2	0	7
Do you feel apathetic about what happens to the people you care for professionally?	Every day	18	3	0	21
	A few times a week	0	1	0	1
	A few times a month	1	0	1	2
	Never	1	0	0	1
Do you feel motivated to work after close, personal contact with patients?	Every day	18	3	1	22
	A few times a week	0	1	0	1
	A few times a month	1	0	0	1
	Never	1	0	0	1

they were able to save money. Just over half worked more than 36 hours per week.

Over 60% of respondents saw no need for more staff because of the weak demand; this would suggest that most workers don't feel overworked. More than a third reported that they lacked resources. Twelve per cent reported conflicts with their co-workers. Sixty per cent were concerned about losing their job, although most were not concerned about their job at the cooperative. Nearly all respondents worked fixed schedules. They felt their labor rights were respected and were not affected by the ir working for a cooperative.

Most respondents felt their workplace was clean, safe and hygienic. No respondent had experienced or knew of any occupational accidents.

Work organization

Only half the nurses worked in teams; the remainder worked alone. All members of the Cooperative reported working in teams. More than half of respondents reported that there were few opportunities for debate and reflection on the organization of their work.

The Junín Cooperative tries to distinguish itself from other private or public institutions through its horizontal and egalitarian management structure. Nonetheless, almost all respondents believed that there were authorities in the Cooperative who made management and organizational decisions. Only a few professionals did not perceive this authority. All members recognized that the authority resided in the Administrative Council and was exercised through horizontal and egalitarian mechanisms. Three quarters of the cooperative members felt the Administrative Council did a good job; one quarter felt its work was only average. The Cooperative members had the most negative perception of clinic's authorities.

Working relationships

Interviews and direct observation allowed us to see evidence of tension between members of the Cooperative. There were three distinct groups that fought over power. Members of the Administrative Council spent more time in the Cooperative and considered themselves to be more committed to the development and fate of the Clinic; the other members of the Cooperative felt that members of the Council kept their knowledge to themselves and made decisions without prior discussion with other Cooperative members.

Not being members of the Cooperative, the other workers were oblivious to this conflict. In answering the survey question about authority, they compared their current experience as employees of the Cooperative with prior experiences with officials of other institutions in which they were working or had worked. Nonetheless, 80% of them considered that as workers their interests were the same as those of their employer since either they had the same objectives or because of the cooperative structure. Most respondents felt that their skills were recognized; the Cooperative members were least likely to feel this.

Ten per cent of professionals said they had "rarely" been bothered by mistreatment and workplace conflicts. By contrast half of cooperative members were bothered by such situations; this was not the case for the sole maintenance worker in the survey. Over 70% of respondents stated that their problems were adequately addressed.

Working conditions and their impact on workers' lives

Almost half of respondents said they never feel exhausted at the end their working day. However, a similar proportion felt exhausted daily or occasionally when getting up in the morning and facing another day at work.

More than a third feel unhappy about the low wages at the Cooperative; Only 12% complained of lack of material resources and supplies. However, nearly a third of respondents reported no concerns about their job. Ninety per cent felt that their jobs brought them many rewards.

Impact of working conditions on the care provided to patients

Almost a quarter of respondents said there was nothing in their work environment which kept them from doing their jobs. Over a third cited lack of equipment and resources. Other impediments mentioned were fatigue/exhaustion (16%) and peer conflict (12 %).

Just under half felt they had become harder with other people; only a quarter expressed concern that they had become emotionally hardened.

More than half of professionals cared "always" what happened to the people who came to the clinic. Only one professional reported not feeling motivated by close personal contact with patients;

the lack of demand at the Cooperative makes such personal contact possible.

Conclusions

The Junin Clinic conflict arose during a severe economic recession. In December 2001 an estimated 400 people became impoverished each day in the Province of Córdoba. The possibility of losing ones jobs and not being able to find another way of surviving haunted the daily life of the Province.

Junín workers managed to recuperate their right to work and even to create new forms of health management. They sought to avoid the profit-seeking focus of private institutions and the dysfunctional management structures of public health institutions.

The process of organizing and mobilizing brought new and critical insights about the health care system which they were now joining. The support and exchanges with activists and workers from other recuperated businesses allowed them to formulate demands that went beyond the immediate needs of the clinic. They questioned hierarchical organization, tried out more democratic forms of management, worked in solidarity with the struggles of other workers, and implemented an egalitarian redistribution of income among members of the cooperative.

However, the decision not to allow professionals to join the Cooperative was at odds with their professed ideals of democracy and equality. While professionals were not prevented from participating in meetings, neither was their participation facilitated. It seems that the professionals accepted this situation, as most of them were satisfied by the decisions of the Administrative Council. Nonetheless, it should be emphasized that this lack of participation by professionals is likely to impact on the coordination and teamwork involved in monitoring and integrating health care for individual patients.

While the lack of patients does provide more personalized attention, it limits the cooperative's income. Workers must turn to second jobs in order to supplement their earnings. This would explain the fatigue and exhaustion felt by many professionals.

The International Labor Organization recommends limiting direct patient contact to six hours daily. This recommendation was derived from a findings that iatrogenic events and errors are more common at the end of the working day (Burijovich and Pautassi 2005).

Excessive work hours, lack of equipment or resources, and low wages were sources of worry, tension, fatigue, and dissatisfaction with the care provided. These conditions allow an appreciation of why some professionals develop emotional distance and lack of interest in patients over the years.

In general, workers were willing to participate in the survey which was carried out without difficulty. However, we must remember that while the quantitative analysis allows us to study and measure the conditions under the organization works, it is limited in its ability to capture the peculiarities that form the concrete practices of workers. Survey questions need to be supplemented by direct observation and interviews. These latter techniques provided a more detailed account of the conditions under which the work of the Cooperative is carried out.

Prior research on the Junín Cooperative has not involved quantitative evaluation of working conditions and health care. Existing studies are generally based on observations and interviews conducted with members of the Cooperative and/or their lawyers; they have primarily looked at the process by which the clinic was recuperated.

In summary, our findings offer suggestions for a critical reflection on work organization and management practices at the Cooperative:

1. Rethinking the possibility of active participation by professionals in decision-making in the management of the Cooperative and the organization of work processes.
2. Promotion and encouragement of participation and commitment by professionals working in the Cooperative.
3. Creation of spaces that encourage communication, exchange, and teamwork. This would benefit the monitoring and integration of patient care.

The low demand for clinic services and the consequent limitation on the income of all cooperative workers creates a situation which induces them to seek other jobs; this increases their working hours. The ILO recommendations do not correspond to the current reality of health workers in Argentina.

The employees of the Junin Clinic want to provide accessible and high-quality health care services to their patients. However, the issue of income remains. Without a state subsidy, workers would seem to have only two options: a) increase the price of consultations, which would go against the principle of making health care accessible to the needy,

or b) increase the number of patients.

The Cooperative is committed to this second option. However, it must be stressed that this option could have negative consequences on the quality of care provided.

This dilemma originates in public health policies over which Cooperative members have no control. Changing these policies requires a political struggle to get the State to assume the responsibility for meeting the health needs of the population, providing the necessary financing for equipment and material, and assuring a stable income to workers so they can meet their basic needs with six hours a day of work. This would create conditions to provide better health care and to do away with the business relationship between patient and professional.

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