Editorial

Is it possible to overcome labor precariousness of workers in the health sector?

*Mauricio Torres-Tovar**

[1] Physician, Occupational Health Specialist, Master in Political Studies, PhD in Public Health. Associate Professor, director Department of Public Health, coordinator of the Masters in Public Health. Faculty of Medicine, Universidad Nacional de Colombia, Bogotá branch. Member of the Research Group on Environmental and Occupational Health of the Public Health interfaculty doctorate mhtorrest@unal.edu.co

Torres-Tovar M. Is it possibleto overcome labor precariousness of workers in the health sector?.. Rev. Fac. Nac. Salud Pública. 2023;41(3):e354685 doi: https://doi.org/10.17533/udea.rfnsp.e354685

Various investigations have shown that, as a result of the structural reforms of privatizing nature implemented globally during the 1980s and 1990s and with great force in Latin America, which led, among others, to changes in labor, social security and health systems, a process of flexibility and intermediation was extended that generated a process of labor precariousness for workers in the health sector [1,2,3,4,5,6].

This labor phenomenon has been expressed by forms of temporary hiring for multiple tasks, including missional ones, mainly through figures, like service provision orders, union contracts, labor work or through associated labor cooperatives, which has led to job insecurity characterized by intermediated and unstable forms of hiring, decreased wages, increased working hours, intensification of the workload, lack of health protection at work, and little or no possibility of organization and possibility of collective bargaining [7,8]. A situation that in the health sector has led, as a way to compensate for income, to workers having several jobs simultaneously, which leads to a greater workload and greater wear and tear on their health and lives.

This labor phenomenon is global, impacting different regions of the world. For Latin America, some studies evidence the low quality of the work life of health workers in the region, linked to shortcomings in promotion opportunities and in the personal motivation of workers and the presence of risks to their physical and emotional health, as well as dissatisfaction with labor remuneration, establishing as causes poor working conditions, work overload, salary dissatisfaction, and limited availability of supplies and work tools; situations that arise in public and private health institutions [9,10].

Labor precariousness in the health sector in Colombia

Legislation 100 of 1993 reorganized how health services are provided in Colombia, by incorporating them into a services market with the presence of intermediary institutions for the administration of resources (EPSs) and health service providers (IPSs), which led to work being governed by the managerial logic of market rationality that has interpreted labor as a component of capital extraction and accumulation [8,11]. In this sense, EPSs and IPSs have established a flexible and outsourced hiring model, together with reduced wage amounts, with a work organization that controls times and rhythms and the types of diagnostic and therapeutic resources that can be ordered. This work dynamic has relegated the scientific-technical knowledge of health-sector workers under the cost-benefit managerial logic, leading to deterioration in the quality of life of workers and the quality of services provided. An issue that has been possible due to weak state authority in matters of labor regulation and loss of organizational capacity by workers.

To this work context, which it is worth highlighting is mainly feminine, are added components of the labor organization in the sector linked to loss of autonomy, dissatisfaction, vertical hierarchical relationships, violence, and workplace harassment [12].

This situation constitutes a context of labor precariousness of the health staff in Colombia, reflected – among other aspects – on the type of hiring, duration of work shifts, wage amounts, the number of places where they must work to compensate income, and on the health protection mechanisms in the workplace. This, in turn, configures the conditions for negative effects to occur on the health of workers.

For 2020, in the public health sector in Colombia, outsourced contracts constituted 71.37% of the jobs and servers only constituted 28.63% of the links to the personnel staff of public entities [13,14], with an approximate number for that date of 1,400,000 workers from the health sector in the country, with more or less 20% from the public sector and 80% from the private sector [12].

The workload of health workers has increased, reflected on the number of hours they must work; 32% of general practitioners work between 48 and 66 hours per week, and 14% more than 66 hours per week; rural doctors in this same relationship of hours per week are 40% and 20% and for specialists these are 33% and 14%. [15]. In relation to other health professionals, it is noted that 29% work over 48 hours weekly, finding that 5% work over 66 hours per week. For physiotherapists, 28.2% work over 48 hours per week; 24.2% have shifts beyond their normal workday and 30.9% always take work their home [16].

Regarding wages, the following is observed: in 2013, the professional nursing staff had a monthly salary close to $3,000,000 Colombian pesos and by 2018, this monthly salary had diminished to $2,600,000* Colombian pesos. For general practitioners, 71% earn between three and five minimum monthly salaries and 15% of specialists make less than five minimum monthly wages; 41.5% of physiotherapists earn less than two minimum monthly salaries, 40.7% earn between 2 and 4 and only 17.8% receives > 4 [16].

Overall, 50% of health sector workers have had problems with getting wages paid on time, adding to their depreciation, which has led 77% to feel dissatisfied with their work income, consider that they are being exploited and that they do not see their work efforts compensated [15].

This situation also leads to searching for more than one place of work; 33% of general practitioners work in two or more places, while this work condition is experienced by 68% of specialist physicians [15].

With respect to health and safety conditions at work, the confrontation with the COVID-19 pandemic revealed much limitation in the implementation of the biosafety protocols that all institutions providing health services must develop, together with very limited management of safety and health at work in these institutions, drastically reflected in the lack or shortage of providing health workers with adequate personal protection elements [14,17]. This, undoubtedly, had to do with the painful morbidity-mortality rate due to COVID-19 endured in Colombia among the health staff [18].

These employment and working conditions impact the health and lives of workers in the health sector, generating a profile of occupational pathologies that combines “traditional” ones, such as infectious, dermal, and cancer, with “emerging” ones. ”of osteo-muscular and mental type, among which stress, minor and major depression, burnout syndrome stand out, even leading to suicide attempts and suicide, where today certain groups of health professionals are among the work groups with higher suicide rates [10,19,20].

Options to overcome labor precariousness

With this panorama, the question that is the title of this editorial necessarily arises: is it possible to overcome labor precariousness of workers in the health sector? No doubt, we would have to say yes, but a set of political decisions is required that lead to labor reforms and policies, accompanied by the economic resources necessary to advance in the configuration of dignified and decent work for all workers in the health sector.

One of the fundamental steps that must be taken, is to understand that it is not possible in a society to guarantee the right to health without participation from a broad group of workers in the health area and that, in this sense, a nodal element of the guarantee of the right to health is the guarantee of the rights of those who care for the health of the population.

This implies that society as a whole, governments and enterprises understand that health-sector workers are of vital importance in the task of caring for society, as evidenced by the experience of the COVID-19 pandemic and that this

* Calculation made based on the average contribution base index for social security (IBC, for the term in Spanish) of nursing professionals with dependent work modality.

must be reflected in great social recognition, respectful treatment, and high consideration, represented by decent and dignified work recognitions.

Moreover, transformations are required in the country in labor, health, and occupational risk policies that place the work of workers, their health and the health of the general population, based on well-being and care and not based on the accumulation of wealth; this is nodal to be able to move in another direction.

In this sense and as has been proposed with the labor reform proposal presented by the current National Government, it is necessary to formalize work in the health sector† to generate dignified and decent working conditions, which at least imply stable jobs provided by regular hiring; fair wages; respect for workers' right to association and collective bargaining, and guarantee of the right to workplace health and safety [22].

According to data from the Ministry of Health, 27% (47,243) of missional and administrative workers are formalized; 73% (128,643) would be missing, who are involved with providing services in the 928 existing State Social Enterprises. This formalization is estimated to cost 9-billion Colombian pesos, which would be conducted gradually and would take four years [12].

Advancing in this formalization, surely implies political will by various governmental, parliamentary, union and business actors, expressed in defining the economic resources necessary to achieve it, both for the public and private sectors. It can be argued that it costs too much, but it is necessary to understand that the country has resources that only require reorientation, that they must be directed to a segment of the working population that is fundamental for society. Believing that it is not possible is accepting the fact that thousands and thousands of workers have no other option than to have precarious jobs and lives.

Now, together with the formalization of work, we must guarantee the construction of dignified and safe work environments for all workers, as well as gender equality, establishing equal wages for women and men regarding the same types of tasks and the same possibility of

holding positions of leadership and power, among other aspects [12]. Likewise, it implies affecting the organization of work because it is not only formalizing the work, but the way in which it is conducted must establish the times, rhythms, and loads that avoid damaging the health of workers, as well as the conditions so work is provided with quality standards that protect the health of patients.

A central aspect, also to overcome job insecurity, is the re-composition and enhancement of the associative forms of health-sector workers, which allows them to configure representative unions and guilds that dialogue and influence other actors in the health sector, to establish the necessary decisions and public and entrepreneurial policies to configure decent forms of work in the sector, within a necessary path of democratization of labor relations.

Finally, it must be understood that improving the working conditions of health workers, as suggested by the literature, increases the staff's commitment to their work and positively impacts on the quality of care and its safety, as well as outcomes in population health [9].

Declaration of financing sources

The preparation of the text had no source of financing.

Conflict of interest statement

The author declares that there is no conflict of interest

Disclaimer

The author is responsible for the information declared and its veracity

Contribution statement by authors

The author wrote the entire text

† This approach is part of various judicial pronouncements made by the Courts in the country, one of the latest being that made by the Supreme Court of Justice, through its Labor Chamber, in Sentence SL-3086 of 2021, which described contracts for health personnel as "precarious" and called on judicial and administrative authorities to formalize jobs [21]. Now, according to data from the Ministry of Health, 27% (47,243) of missionary and administrative workers are formalized, and 73% (128,643) are missing, which are linked by provision of services in the 928 existing state social enterprises. It is estimated that the cost of this formalization would be 9 billion pesos, which would be done gradually and would take 4 years [12]..

References

1. Feo Istúriz, Oscar (2003). “Reflexiones sobre la globalización y su impacto sobre la salud de los trabajadores y el ambiente” en Ciência e Saúde Coletiva (Rio de Janeiro) Vol. 8, No. 4.
2. Luna-García, Jairo Ernesto (2009). “Globalización y salud de los trabajadores” en Boletín del Observatorio de Salud (Bogotá) Vol. 2, No. 5.
3. Benach, Joan; Muntaner, Carles; Quinlan, Michael; Solar, Oriel y Santana, Vilma (2010). “Empleo, trabajo y desigualdades en salud: una visión global” (Barcelona: Icaria editorial).
4. Moutsatsos, Chrisy (2011). “La globalización económica y sus efectos en el trabajo” en Schnall, Peter; Dobson, Marnie y Rosskam, Ellen (comps.) Trabajo no saludable. Causas, consecuencias, curas (Bogotá: Universidad de los Andes).
5. Ardila, Adriana (2016). “Neoliberalismo y trabajo médico en el Sistema General de Seguridad Social en Salud. De la profesión liberal al trabajo explotado”, Tesis de Doctorado, Bogotá.
6. Antunes, Ricardo (2018). “A sociedade dos adoecimentos no trabalho. In: O privilegio da servidão: o novo proletariado de serviços na era digital” (São Paulo: Boitempo).
7. Standing, Guy (2011). “The precariat. The new dangerous class” (London: Bloomsbury).
8. Torres-Tovar, Mauricio. (2021). Covid-19: pandemia y precariedad laboral en el sector salud y su impacto en la salud de las y los trabajadores. En Carolina Tetelboin Henrion et al. (eds.), América Latina. Sociedad, política y salud en tiempos de pandemia (pp. 291-308). Buenos Aires: CLACSO; Xochimilco: Universidad Autónoma Metropolitana; Xalapa: Universidad Veracruzana; Cochabamba: Universidad Mayor de San Simón; Valparaíso: Universidad de Valparaíso.
9. Caicedo Fandiño, H. Y. Calidad de vida laboral en trabajadores de la salud en países latinoamericanos: metaanálisis. SIGNOS-Investigación en Sistemas de Gestión, vol. 11, núm. 2, pp. 41-62, 2019.
10. Rodríguez, Carlos Aníbal (2010). “Condiciones de trabajo en el sector salud” en Luna García, J, Cuspoca Decsy y Vásquez Laura (comps.) Trabajo, crisis global y salud. Memorias 70. Seminario internacional (Bogotá: Universidad Nacional de Colombia).
11. Hernández Álvarez, M. (2019). Sistemas universales de protecciones sociales como alternativa a la Cobertura Universal en Salud (CUS). Saúde em Debate, 43(spe5), 29-43. https://scielosp.org/pdf/sdeb/2019.v43nspe5/29-43/es
12. Molina Achury, Nancy. (marzo, 2023). Dignificar el trabajo de quienes cuidan la vida en Colombia. Periódico Desde Abajo. Edición Extraordinaria. Págs.: 9-10. https://www.desdeabajo.info/rotador-incio/item/dignificar-el-trabajo-de-quienes-cuidan-la-vida-en-colombia.html
13. Procuraduría General de la Nación. Circular 007 del 10 de diciembre de 2020 https://www.periodismoinvestigativo.com.co/wp-content/uploads/2021/01/Circular-007- trabajadores-salud-revisada-DJGA-10-12-2020.pdf
14. Molina Achury, Nancy. (2020, August 20). El COVID-19 y el sector salud: desprotección, precarización laboral y exceso de carga mental. Periódico UNAL. Retrieved from https://unperiodico.unal.edu.co/pages/detail/el-covid-19-y-el-sector-saluddesproteccion-precarizacion-laboral-y-exceso-de-carga-mental/
15. Colegio Médico Colombiano (2019). “Encuesta Nacional de Situación Laboral en Salud” (Bogotá: Colegio Médico Colombiano).
16. ASCOFI – Asociación Colombiana de Fisioterapia (2015). “Estudio nacional de condiciones de salud y trabajo de los fisioterapeutas”. Bogotá: ASCOFI.
17. Torres-Tovar, Mauricio (2020). “Lo que devela los tiempos de pandemia al trabajo y a la salud en el trabajo” en Semanario Virtual Caja de Herramientas (Bogotá), No. 680.
18. INS – Instituto Nacional de Salud (2022). “COVID-19 en personal de salud en Colombia” en Boletín (Bogotá) No. 139.

http://www.ins.gov.co/COVID19PERSONALDESALUDCOLOMBIA/INFOGRAFIA%200208 2022.pdf

19. Galíndez, Luis, y Rodríguez Yuraima (2007). “Riesgos Laborales de los Trabajadores de la Salud” en Salud de los Trabajadores (Maracaibo) Vol. 15, No. 2.
20. Torres-Tovar, Mauricio, y Corcho Mejía, Carolina (2019). “Burnout y suicidios, consecuencias del acoso a profesionales de la salud” en UN Periódico Digital (Bogotá).
21. Colombia. Corte Suprema de Justicia. Sentencia SL-3086, Radicación 79229, Acta 24, Magistrado Ponente Jorge Luis Quiroz Alemán. 2012 jun. 30 [cited 2023 Aug. 12].. Available in: https://www.cortesuprema.gov.co/corte/wp-content/uploads/relatorias/la/bago2021/SL3086-2021.pdf
22. OIT - Organización Internacional del Trabajo (2012). Del trabajo precario al trabajo decente. Documento final del simposio de los trabajadores sobre políticas y reglamentación para luchar contra el empleo precario, Ginebra.