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The configuration of nursing labor conditions in the Buenos Aires Metropolitan Area: An analysis at the intersection of the gender order and the organization of the health system

La configuración de las condiciones laborales de la enfermería en el Área Metropolitana de Buenos Aires: un análisis en el cruce del orden de género y la organización del sistema de salud

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ABSTRACT The article explores two key factors which contribute to shape the poor working conditions of nursing in Argentina. A first objective focuses on exploring the effect of the occupation's care component, closely associated with cultural images of "inherent" female qualities, on working conditions. A second objective aims to examine the way in which the organization of health services provision in Argentina intensifies the vulnerability of this occupation. Regarding the methodology, the fieldwork conducted in the Metropolitan Area of Buenos Aires included in-depth interviews with key informants and group interviews with nurses. Among the results, on the one hand it is shown how the social devaluation of care is reflected in the discourse of those who perform the occupation as well as in institutional practices and policies in the health sector. On the other hand, it is shown that the decentralization and fragmentation of the health system act as additional obstacles hampering the articulation of labor demands.

KEY WORDS Nursing Staff; Working Conditions; Women, Working; Argentina.

RESUMEN El artículo indaga dos factores centrales que contribuyen a la configuración del endeble panorama laboral que presenta la enfermería en Argentina. El primer objetivo se centra en explorar cómo incide en las condiciones de trabajo el componente de cuidado, culturalmente asociado a imágenes sobre saberes y habilidades supuestamente "innatas" de las mujeres y, el segundo, en indagar cómo la forma en que se organiza la provisión de los servicios de salud en nuestro país intensifica la vulnerabilidad de esta ocupación. En cuanto a la metodología, el trabajo de campo realizado en el Área Metropolitana de Buenos Aires incluyó entrevistas en profundidad a referentes de la actividad, así como entrevistas grupales con enfermeras y enfermeros. Entre los resultados se muestra, por un lado, cómo la devaluación social del cuidado está presente en discursos de quienes ejercen la ocupación, así como en las prácticas y políticas institucionales del sector salud. Por otro lado, se evidencia cómo la descentralización y la fragmentación del sistema de salud se presentan como obstáculos adicionales, dificultando la articulación de reclamos laborales.

PALABRAS CLAVES Personal de Enfermería; Condiciones de Trabajo; Trabajo de Mujeres; Argentina.

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INTRODUCTION

The analysis of the labor conditions of care workers has gained increasing significance in the feminist agenda over the last years. Such concern falls within a relatively recent line of work that comes from Anglo-Saxon feminist economics – but with important developments at a regional level – which has emphasized the category of *care* more than other prior ones such as *domestic work* or *reproductive work*.[1,2,3,4] While pioneering works on feminism were focused on bringing to light the lack of economic recognition of the reproductive household work carried out by women on a non-remunerated basis, highlighting that it entails a fundamental contribution to the reproduction of work force,[5,6,7] some studies based on the care category seek to shift the attention from the *place* where these tasks are developed to the *type of work* assigned to women and its persistent social and economic devaluation. This approach serves to expand borders beyond reproductive work within households in order to observe what happens in the performance of certain tasks that entail an extension of supposedly "female" skills within the remunerated sphere of the market.

Trends like the increase in female labor participation over the last decades together with demographic changes – for instance, the process of population aging or the decrease in the size of households resulting in the decrease of family support networks – have led to a bigger demand for remunerated care services. This phenomenon involves a necessary (and new) attention oriented towards the development of care-related occupations. In turn, the significant level of feminization of these occupations show them to constitue a sector that generates job opportunities for many women.[1]

Who are care workers? In general, care workers are those who perform activities that contribute to an individual's health, physical safety, and development of cognitive, physical or emotional abilities, and who interact directly with those receiving the service in question.[8] Typically, these occupations include teachers of all education levels, therapists, doctors and nurses, and they are concentrated in the health sector as well as in the education sector.

Existing studies have discussed this subject from the point of view of the care workers' labor conditions as compared to the labor conditions of occupations not related to care, with the hypothesis that because they involve tasks which are socially undervalued – closely associated with skills and abilities that are supposedly inherently female – they could suffer a potential penalization on the market in terms of remunerations and labor conditions. In addition, these studies have explored what other variables – basically political-institutional factors which shape the way each particular occupational dynamics is organized, regulated and disputed – combined with care may reduce or increase the penalization involved when engaging in these types of occupations.[8,9,1,11]

This work seeks to contribute to that host of knowledge focusing on the specific case of nursing in the Buenos Aires Metropolitan Area (AMBA) [*Área Metropolitana de Buenos Aires*].[a]

Performing the nursing occupation involves the provision of a key social service. The nursing personnel, on the basis of their knowledge and skills, are those that provide the necessary care for health promotion, recovery and maintenance processes.[14] Unlike other care occupations, in which care constitutes just one *component* among others, nursing has the particular feature of defining itself in terms of its objective and mission to provide care. Furthermore, and in line with the abovementioned comment about care occupations in general, nursing constitutes a highly female-dominated occupation.[15]

By and large, the existing literature on the subject in Argentina narrates a series of "typical" problems surrounding this occupation that mark a significant level of precariousness: low salaries, moonlighting, job-related stress and lack of suitable equipment and infrastructure, to name just the most relevant examples.[15,16,17,18,19,20,21,22] Other problems

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which are often identified have to do with the permanent biological, chemical and physical risks, with musculoskeletal and joint pathologies produced by the physical efforts that these tasks require, as well as altered sleep patterns and fatigue, mainly among women working night shifts who have to combine their work with domestic responsibilities.[10] In addition, lack of human resources constitutes one of the major problems affecting this occupation; this labor shortage is reflected not only in the scarce number of nurses on duty and the resulting work overload that this situation entails, but also in their qualifications, resulting in a quantitative and qualitative deficit in human resources.[23,24]

The final purpose of this article is to contribute to the existing knowledge regarding the key factors that structure nursing labor conditions in order to generate new elements that prove useful in thinking about policies oriented toward this occupation. In this sense, the intention here is to address two factors that, while not aimed at exhausting the analysis of the problem, appeared as central in our investigation about the configuration of the nursing labor scenario.

In this way, the first specific objective focuses on exploring the effect of the care component on labor conditions. The literature on this subject claims that the care-related tasks, strongly associated with traditional images of gender – and, accordingly, identified with skills and abilities supposedly inherent to the female condition – prevent this occupation from being perceived as an "authentic job." Thus, the first part of this article discusses the difficulties that care involves in the construction of a "professionalized" discourse about this occupation, as well as the way this devalued image of care is reflected in institutional policies and practices within the health sector.

At the same time, as noted above, the analyses on the subject also show that the political-institutional contexts in which this type of occupation is developed are of great significance when it comes to reinforcing or mitigating the social devaluation of care. For this reason, the second specific objective is to explore how the organization of the health service provision in Argentina intensifies the vulnerability of this occupation. In particular, we will focus on how the decentralization and fragmentation of the health sector mark differences in work experiences and hamper the possibilities for articulating labor demands.

METHODOLOGY

The methodology used in this work was qualitative. The fieldwork was conducted between September 2013 and May 2014 within the Buenos Aires Metropolitan Area (AMBA). On the one hand, a series of in-depth interviews were held with key informants related to the occupation, including directors of nursing programs offered at both public and private universities, heads of nursing departments (in the case of the public sector, national, provincial and municipal key informants were included) and trade union leaders. On the other hand, two group meetings were held with advanced students of the Nursing undergraduate degree program who were already engaged in professional practice: one was held at a private university located in the Autonomous City of Buenos Aires, in which 26 students participated, and the other at a public university located in Greater Buenos Aires, in which 15 students participated. The ages ranged between 25 and 56. In both cases, a larger number of women (more than 90% of the total) older than 40 years of age (more than 60% of the cases) were present. While the work of the great majority involved direct patient care, the participants also included floor supervisors, area coordinators and one female department chief. The people interviewed worked in different spheres: national, provincial and municipal hospitals, as well as clinics, medical centers and private nursing homes for the elderly.

Regarding ethical criteria, the express consent of the people interviewed was requested and obtained. When invited to

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participate in our research, participants were informed about the purpose, duration, methodology and finalization criteria for their participation, emphasizing the right to leave at any time if they so desired. Furthermore, in order to preserve information confidentiality, all data that could be used to identify the participant were coded with the aim of protecting personal details, protecting their identity and guaranteeing anonymity. The researchers explicitly committed themselves to preserving the appropriate confidentiality regarding the personal details of all the participants in the project, both in the processes of obtaining, working with and saving data, and in the ensuing publication of the findings.[b]

RESULTS

Care and the difficulties in constructing a professionalized discourse of the occupation

As highlighted above, nursing has the particular feature of defining itself almost exclusively in terms of its mission and objective to offer care. In fact, among the people interviewed, the care component of the occupation is emphasized to define its specificity and specialty as compared to other health professions, mainly medicine:

> *I have to be settled in my role, in the situations I know how to participate in, because I understand clearly that my task is different from that of a doctor. A doctor diagnoses, I am a care specialist, so I can talk from that position. But I have to be secure, and I have to get such confidence from formal knowledge.* (Program Director, public university)

> Female nurse 2: *We are paid to provide care.*

> Female nurse 17: *You're not an assistant but part of the health team.*

> Female nurse 6: *You're part of the interdisciplinary team to make decisions regarding the care and treatment of a patient, not just to obey orders.* (Group interview No. 1)

Nevertheless, this discourse aimed at constructing care work as a specialization requiring specific knowledge often appears tinged with other conceptions. Thus, the images of gender that associate the ability to provide care with skills and inclinations "inherent" to the female condition are strongly present in the reflections expressed by the female nurses interviewed. In this sense, there are plenty of references to supposedly typical female qualities that would enable them to provide a better care, such as "intuition" (that would allow them to better perceive what is happening with a patient), the "innate" tendency to give protection and/or the training provided by the experience of maternity, among others.

> Female nurse 1: *You have that sense of intuition. One perhaps sees or perceives that something is happening to a patient and that is typical of a woman...*

> Female nurse 9: *The instinct that we have.* (Group interview No. 1)

> Female nurse 34: *Well, also, perhaps a woman has that... how can I put it into words?* [...] *that ability to protect, to take care of someone; perhaps taking care of someone comes naturally to us.*

> Female nurse 35: *Just like with having children...* (Group interview No. 2)

Even the discourses of the interviewees who were more committed to the construction of a more professionalized vision of the occupation were permeated with gender images associated with care:

> Female interviewee: *We have to be clear, we are not assistants, we are not maids; we are care specialists! We are*

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part of an interdisciplinary work team. We have to support this demand with better training.

Female interviewer: *Would you say that female nurses work the same way as male nurses?*

Female interviewee: *A female nurse is sort of more protective of the patient. This doesn't mean that a male nurse's work is not enough, but a female nurse is more protective in terms of care, I think so because of the very essence of being a woman* [...] *It has to do with ... being moved, being moved by a patient's situation, their family situation, their social situation* [...] *being moved by everything.* (Trade union leader, individual interview)

These types of associations that emerge between nursing and "innate" female qualities place the occupation in an ambiguous situation in terms of its comparison to a job "like any other," which requires knowledge and specific qualifications, which entails rights and the ability to defend those rights. In this sense, for instance, the presentation of the self and of an occupation as being motivated by sacrifice – many times putting it on the same level with maternal sacrifice – is a relatively common situation among the female interviewees and is scarcely questioned in terms of labor rights and needs:

Definitely, we are all motivated by vocation, taking care of patients, making sure they are all right. Sometimes my legs ache [the female interviewee has two jobs], *from standing for hours on end or rushing about, or I didn't have enough time to eat, but you see them all depending on you and that makes you strong ...* [...] *Or a lot of coworkers are absent and you see that a hard shift is about to come... I mean, you have to like this job because you make a lot of sacrifices... many* [students] *quit during internships, they can't cope with it, that's why I'm telling you have to have a vocation for this* [...] *but the satisfaction you get when you see you are helping, that you are taking care of another person and that the patient needs you, it's all very powerful, it makes you strong.* (Female nurse 37, group interview No. 2)

It was interesting to have the presence – although in a minority – of males in the group conversation since it helped to challenge these perceptions. In this sense, the increase in the number of males which is being observed in the youngest cohorts of the occupation[25,26] could constitute an important element to deconstruct the gender stereotypes associated with the occupation:

Male nurse 10: *Sorry, but a male can also provide care. Besides, men have children as well. What do you mean, that because I am a man I'm going to be worse at providing care?* [In reference to the association between maternity and care ability].

Male nurse 8: *No, I don't agree. We are trained to provide care and that is not going to be different if you are a female or a male* [In reference to the instinctive and female nature of care suggested by a female participant].

Female nurse 2: *Yes, you're right, what she says is because historically anything to do with care... that role has always been assigned to women...* (Group interview No. 1)

Devaluation of care observed through institutional practices and policies

The cultural association between care and stereotyped images of gender undoubtedly correlates with the social and economic valorization of this occupation. In this section our aim is to explore how the devaluation of care in nursing is expressed through institutional practices and policies.

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A first issue that shows the de-hierarchization of care at an institutional level has to do with a health system that uses human resources in nursing with minimum levels of qualifications. In effect, anyone can undertake this occupation with basic preparation requirements: based on the latest data available, almost one half of the human resources of this occupation (48%) hold a nursing "assistant" degree, which only requires a one-year training program in low complexity care. It should be noted that, until 2006, anyone who had completed primary education could pursue a nursing assistant degree. After the enactment of the National Education Act, the completion of secondary education studies became a requirement. The subgroup that follows in terms of relative weight is that of nursing personnel with technical training (41% of this work force), which takes three years in post-secondary or university institutions. Finally, only 11% has an undergraduate degree in nursing (Figure 1). Certainly, this situation is not detached from the situation of scarcity of human resources, but it is important to highlight that, beyond some occasional and/or discontinuous initiatives,[27] this occupation has not been accompanied by extended and supported policies of reconversion of the lower levels of qualifications, nor has it received national plans for professional training of nursing staff.

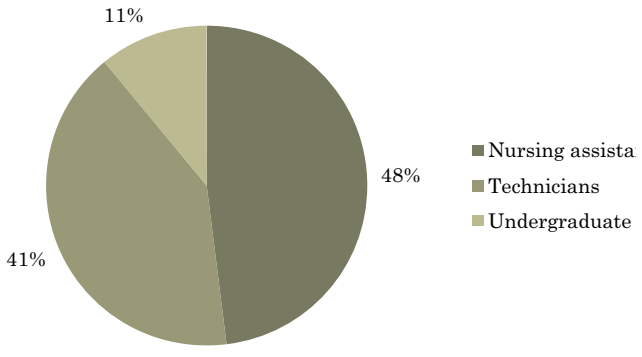

Figure 1. Percentage distribution of the professionalization of nursing human resources. Argentina, 2014.

Source: Federal Record Network of Health-Care Professionals (REFEPS) [*Red Federal de Registros de Profesionales de la Salud*], Integrated System of Argentine Health Information (SISA) [*Sistema Integrado de Información Sanitaria Argentina*], Federal Ministry of Health.

A second issue, closely linked with the one mentioned above, has to do with the institutional place in which the nursing personnel is positioned, or to which it is confined. While the medical personnel form part of the "professional" staff within institutions, the nursing personnel most of the time are part of the "non-professional" staff within the health system. In this sense, nurses are part of a heterogeneous set of occupations made up of administrative, maintenance, cleaning, and stretcher workers, among others. Likewise, and as a result of this division, in the public sector the nursing personnel are often left out from what is known as the "hospital career" which pays relatively higher remunerations than those paid to "non-professional personnel" and generates regulated opportunities for promotion and better working conditions, apart from facilitating access to hierarchical positions, in a scheme which tends to exclude nursing. This panorama is observed in a critical way by a trade union leader regarding the situation of the public health subsector in the Autonomous City of Buenos Aires:

> *Our proposal is a global sociosanitary grade scale* [...] *that ranges from doctors to the cleaning staff, all of us who work in the health field. So far what we have is a hierarchical and elitist system; the current situation is that doctors fall within what is known as the "hospital career," which is the salary grade scale you get if you are a doctor, but the rest of the workers all fall within the general grade scale* [...]. *From the very beginning, nursing is not considered part of the hospital career, and this is not a minor fact, this already puts you in a devalued place socially and, logically, economically as well...* (Male trade union leader, individual interview)

Nevertheless, it is striking that the nurses interviewed often fail to challenge

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spontaneously this basic occupational segmentation in the health sector. In general, the comparisons which serve as parameters to assess that the occupation is not "valued" usually relate to the salaries paid to other "non-professional" health occupations inside their working establishments, such as maids and administrative workers, among others.

> Female nurse 20: *We get one thousand or one thousand five hundred Argentine pesos more in our basic salary than what maids collect. It is OK, maids have to be well paid, I think it is great*.
>
> Female nurse 17: *But it is not recognized, you do your training, you study...*
>
> Female nurse 23: *I earn the same as the cleaning staff. Really*.
>
> Female nurse 2: *And compared with an administrative worker, it's not so different either. And perhaps they only completed their secondary studies. I don't want to discredit their work. Each has their own responsibilities. But when it comes to comparing salaries... I know female administrative workers that have two people reporting to them and earn twice the amount I do. I have five or six people reporting to me*. (Group interview No. 1)

This division between professional and non-professional personnel has its correlation in terms of union representation, which reflects and reproduces this split. While the medical personnel are members of professional associations, which are relatively homogeneous and have greater bargaining power than any another type of health occupation, nursing is represented by much more heterogeneous trade unions having a smaller capacity for confrontation. In the private sector, this role is assumed by the Argentine Federation of Health Workers' Associations (FATSA) [*Federación de Asociaciones de Trabajadores de la Sanidad Argentina*], which gathers non-medical personnel in the private health sector. In the public sector, the scenario is much more complex. Here workers may be represented by big state-run trade unions, such as the State Employees' Association (ATE) [*Asociación de Trabajadores del Estado*] or Civil Personnel Union of the Nation (UPCN)[18] [*Unión de Personal Civil de la Nación*], and/or by provincial and municipal public employees' trade unions. Likewise, there are some specific trade unions of non-professional public health workers, such as the Public Health Trade Union [*Sindicato de la Salud Pública*], which has a significant role in the province of Buenos Aires.

In view of this scenario, the strong demands made by most of the nurses interviewed, regarding work interactions in which the social devaluation of nursing becomes evident, are not surprising. In our exploration, the nursing personnel interviewed complain that the medical staff "just give orders," that there is no cross-consultation with nurses, and they even stated that they feel treated like "assistants" or "helpers." In fact, and as indicated in the literature dealing with this subject, the development of nursing tasks is marked by a system which is historically structured around patriarchal and doctor-hegemonic notions.[27] If interaction with the medical staff suggests important continuities in this sense, this also seems to be the case of the interaction of the nursing staff with patients and their families. Therefore, their stories indicate that, in the private sector, female nurses are frequently confused with and treated like maids while, in the public sector, the complaints suggest that the nursing personnel are found among the first victims of aggression (verbal and even physical) in situations of resource shortages that make the provision of care difficult. These types of experiences, which constitute an additional angle from which to account for the subordinate position of the nursing personnel within the health system, can only be understood in the light of relations of power that are supported in cultural constructions relative to the (de-)hierarchization of care tasks performed mainly by women.

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Additional challenges posed by the health sector decentralization

While the care component of nursing poses important challenges as regards the social and economic valorization of the occupation, just as we commented in the introduction, there are other variables that may have an impact on this situation. In the following paragraphs, we will explore the additional obstacles and challenges presented by the performance of nursing activities within a health system that is highly decentralized and fragmented in political, administrative and financial terms.

The scarcity of statistical data about the health sector in Argentina prevents us from quantifying the nursing distribution in the different subsectors of the system with precision. In view of these limitations, we can only approach this phenomenon through some indirect indicators.

On the one hand, although it does not allow us to isolate nursing as a specific occupation, the Permanent Household Survey (EPH) [*Encuesta Permanente de Hogares*] provides data on the total distribution of health human resources according to public or private sector. As shown in Figure 2, based on the latest data available for the year 2014, 42.3% of health personnel declared that their major occupation took place in the public sphere, while 55.1% declared employment in private establishments, and 2.5% of the people surveyed reported to be working in "another type of institution." Although the latter data could refer to the subsector of employment-based insurance [*obras sociales*], this cannot be affirmed with certainty due to the lack of an explicit statement in the survey design.

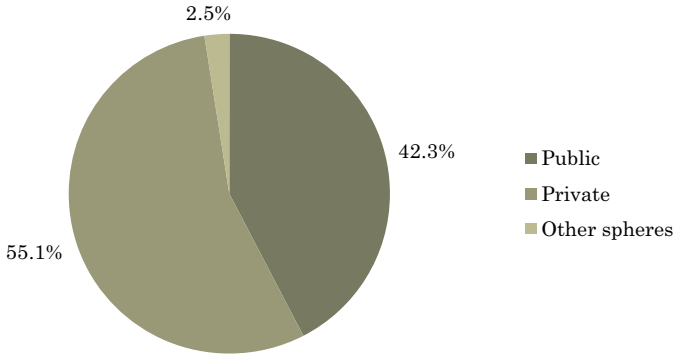

Figure 2. Percentage distribution of people working in the health sector, by public/private subsector. Main urban agglomeration, Argentina, 2014.

Source: Permanent Household Survey, second quarter, 2014.

Moreover, an additional proxy indicator with which to approach the different kinds of employment of health human resources is the distribution of health establishments per subsector. Undoubtedly, this approach involves the logical misrepresentation brought about by differential sizes in the establishments and, consequently, varying amounts of human resources that each may take on. Nevertheless, in the absence of information sources with respect to such a significant phenomenon when analyzing the health personnel in Argentina, these data are presented in order to create a first approach to the subject. According to the information provided by the Federal Health Establishments Record Office[28] [*Registro Federal de Establecimientos de Salud*], the public-sector establishments account for 45% of the total (including all the care establishments of the official, employment-based and private subsectors whose activity consists exclusively of health care of any kind: outpatient attention, hospitalization, day hospital, scheduled home care, diagnosis, treatment, preventive medicine, emergencies and transfers, and any combinations thereof).

A more detailed breakdown based on jurisdiction indicates that most of these establishments are provincial (27% of the total establishments in Argentina), followed by municipal (which account for 17% of the total), while national establishments represent the lowest percentage (only 0.2% of the total). In turn, the private sector concentrates more than one-half of the health establishments in Argentina (53%). Finally, the tendency of employment-based insurance to outsource services in the public sector as well as in the private sector is reflected in the low

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proportion (only 1%) of health establishments managed directly by these entities (Figure 3).

Even though the data disclosed hinder making precise assertions with respect to the nursing personnel distribution per sector, they make it clear that the insertion of nursing personnel in Argentina – as well as that of health workers in general – takes place in dissimilar contexts. The first division that appears to be more visible is that of the public and private spheres. Nevertheless, as we will discuss below, inside these spheres the panorama also presents clear fragmentation. In the case of the public sector, such fragmentation is mainly marked by the jurisdictional level of the establishments. In the private sector, the differences are anchored in a broad spectrum of companies that are different in terms of their capital and the scale that they handle, the cost of their services and the quality provided. How is this prevailing heterogeneity reflected in the sphere of the work performed by nurses according to their own perceptions?

In the first place, general comparisons arise in relation to the public/private insertion. A first issue often mentioned by the interviewees is the greater stability that the insertion in the public sector would guarantee, which would amount to a job "for life" ("*it is for the rest of your lifetime*," "*you'll be fired only if you go and kill someone*"). In this sense, it is not surprising to hear the interviewees say that entering the public sector is less likely than entering the private sector ("*it is really difficult to enter*," "*you have to be lucky enough for a vacancy to open*").

In general, insertion in the public sector appears to be associated with stability and formal employment. Indeed, the problems related to poor employment conditions become more evident in the private sector, especially in small businesses, and linked to non-registered employment. Even though it has been observed that in the public sector there are poor employment conditions – being hired without a registered employment scheme, by which someone is hired under an agreement for the provision of services or the execution of work[16] – these methods would have a greater impact on medical professionals.[8]

> *It depends on the type of establishment* [...] *different things may happen* [...] *from big associations with excellent reputation to small nursing homes for the elderly, very small companies offering home care* [...] *sometimes subject to extremely bad labor conditions* [...] *Sometimes, some people working under the table come to me and I say, "But your work is unregistered, the first thing we have to do is to file the required documentation." And they say, "No, no, my boss can't register my employment,"* and they say, *"No, no, no,"* and go away. (Female trade union leader, individual interview)

Another problem frequently underlined by the interviewees is the overload of patients and the resulting need to "*do a million things,*" "*to be in charge of everything.*" Even though the issue affects both the public and the private sector, the stories suggest that the situation presents heterogeneities towards the inside of the latter ("*it depends on where you work*").

In fact, within the private sphere a clear distinction appears regarding the "category"

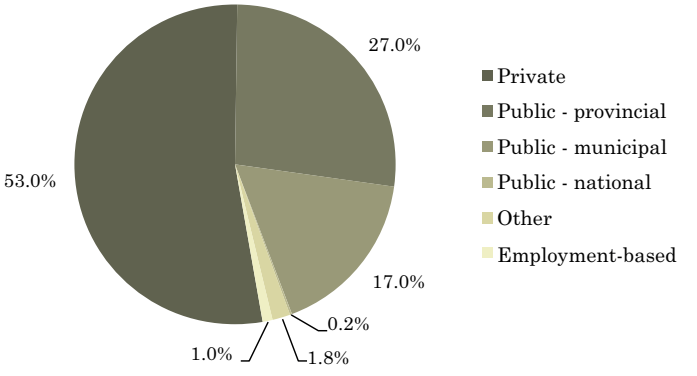

Figure 3. Percentage distribution of health establishments, based on subsector and jurisdiction. Whole country, Argentina, 2014

Source: Federal Health Establishment Record Office (REFES) [*Registro Federal de Establecimientos de Salud*], Federal Ministry of Health.

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of the establishments. In the words of one trade union leader of this sector:

> *There are places in which you can do your work very well, with conditions... I am not going to tell you optimal conditions because there is no such thing as optimal but with very good labor conditions, but others are terrible, with huge patient overload. What prevails is patient overload* [...] *in the clinics you are sold the service, there you have a good patient-doctor relationship* [...] *obviously they have a client, whom they consider extremely demanding, so they try not to overload a nurse's work* [...] *then you have a gradual deterioration* [...] *I would say there are second-rate clinics. Mutual associations that have agreements with employment insurance entities, under the Federal Pensioners' Welfare and Social Security Institute (PAMI)* [Instituto Nacional de Servicios Sociales para Jubilados y Pensionados]... *the nursing homes for the elderly in general* [gesture of disapproval]... *the owners, I mean, they are ranch owners, so the working conditions are very bad.* (Female trade union leader, individual interview)

As regards remunerations – always within the framework of what were referred to as *"very low salaries"* – at the moment of the interview the participants coincided in highlighting that, with the exception of the public establishments of the Autonomous City of Buenos Aires, the private-sector remunerations were higher than those paid in the public sector. Nevertheless, the differences in terms of salaries between both sectors are related to situational factors, which are subject to budgetary ups and downs:

> *For a long time there was migration from the private to the public sector, and this happened about four or five years ago, when the public sector opened its doors to fill vacancies, at that moment the salaries* [in the public sector] *were better than those paid in the private sector* [...] *now the private-sector salaries are higher than the public ones, a lot higher I would say.* (Female trade union leader, individual interview)

Likewise, within the public sector, the comparisons made by interviewees regarding salaries paid in different jurisdictions reflect the heterogeneous nature of the situation. Beyond the many differences of their narratives, the underlying situation seems to be the expected one, where jurisdictions with bigger budgets can offer somewhat better remunerations.

> *In my case, I quit my job at the municipal* [hospital] *when I had the chance. I passed over to the provincial one, because the salary is better. Even though the municipal hospital was closer to my house, it wasn't worth it at all. Everyone wants to move* [from the municipal to the provincial hospital]. (Female nurse 32, group interview No. 2)

> *Here everyone looks to enter into the provincial level* [he is referring to the province of Buenos Aires]. *The fact is that the salary paid by the municipal sector is extremely low, much lower than a provincial salary. I can mention specific examples, in the cities of 25 de Mayo, Coronel Suárez... the basic salaries are shameful. Now, if you go and work for the Government of the City* [of Buenos Aires] *the salaries are a lot higher than the provincial ones.* (Male Program Coordinator, public university, individual interview)

> *We see how people keep on acquiring experience, they keep on training, some of them even study, we encourage them to study, but perhaps when they finally graduate they get a job in the City* [referring to the City of Buenos Aires] *and they leave.* (Female head of Nursing Department, municipal hospital, individual interview)

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Finally, and completing the panorama of salary disparity, workers in many companies within the private sector – depending on their magnitude – can negotiate salaries above the minimum basic salary agreed upon by the sector.

> *Then, for example, you say* [she mentions a private health insurance company] *is a company that earns much more and they get extra-collective bargaining deals over the basic salary signed in the agreement. The same thing happens in* [she mentions other three private health insurance companies]... *the trade union negotiates with the delegates and the relevant employer... they get good salaries, after all, don't they?* (Female trade union leader, individual interview)

The situation of fragmentation in terms of work and salary experiences has its logical correlate in a highly split trade union structure. This division may be reflected in two levels. On the one hand, the trade union fragmentation reflects and reproduces the political structure of the health sector, which differentiates levels of representation at the private and public level and, within the public level, branches out into several entities that carry out the bargaining in each jurisdiction. In addition, as noted in the previous section, the trade union disparities also have to do with the hierarchization of personnel between "professionals" and "non-professionals," nursing being generally pigeonholed in the latter category (Figure 4).

The important disparity in trade union representation in nursing undoubtedly subtracts bargaining power from the workers of this occupation. If this situation helps to understand the predominance of low remunerations, it also serves to put problems in context like that of the systematic extension of workdays (through overtime implementation), as well as the generalized moonlighting existing in the occupation.

Indeed, one of the "compensatory" mechanisms for low salaries is the extension of workdays through overtime within the same establishment. Even though this is a widespread practice, there are some nuances. An extreme case is the City of Buenos Aires, where the nursing personnel may even duplicate the number of hours of a workday through so-called "modules," which are the equivalent of overtime and are arranged in six-hour time blocks. According to the assertions of the interviewees, this precarious component of remuneration through systematic overtime (it is not stable, it generates unending working days) is naturalized among those who perform this occupation:

> *This module thing is so well-established* [...] *that it is like a legitimization of a double salary*. [...] *modules are distributed* [...] *it is a power resource.* (Government official of the area of Human Resources, Ministry of Health, individual interview)

While the overtime scheme in the private sector is also largely widespread, the case of the hospital workers under the jurisdiction of the government of the province of Buenos Aires has experienced a significant change that has aroused expectations of being reproduced among many workers of other subsectors and jurisdictions. In this sphere, nursing tasks were recently declared "unhealthy." This decision has led, among other things, to the reduction of the workday from eight to six hours daily, the possibility of early retirement, and the restriction of the amount of overtime that can be worked.[c]

Regardless of the different regulations in connection with the amount of additional hours and the way they can be added to a workday within the same establishment, there is another scheme that amounts to the systematic over-exploitation of this labor force. We refer to the widespread situation of moonlighting, an issue that has already been observed in health work in general,[22,29,30] and often mentioned by the interviewees in the case of nursing in particular:

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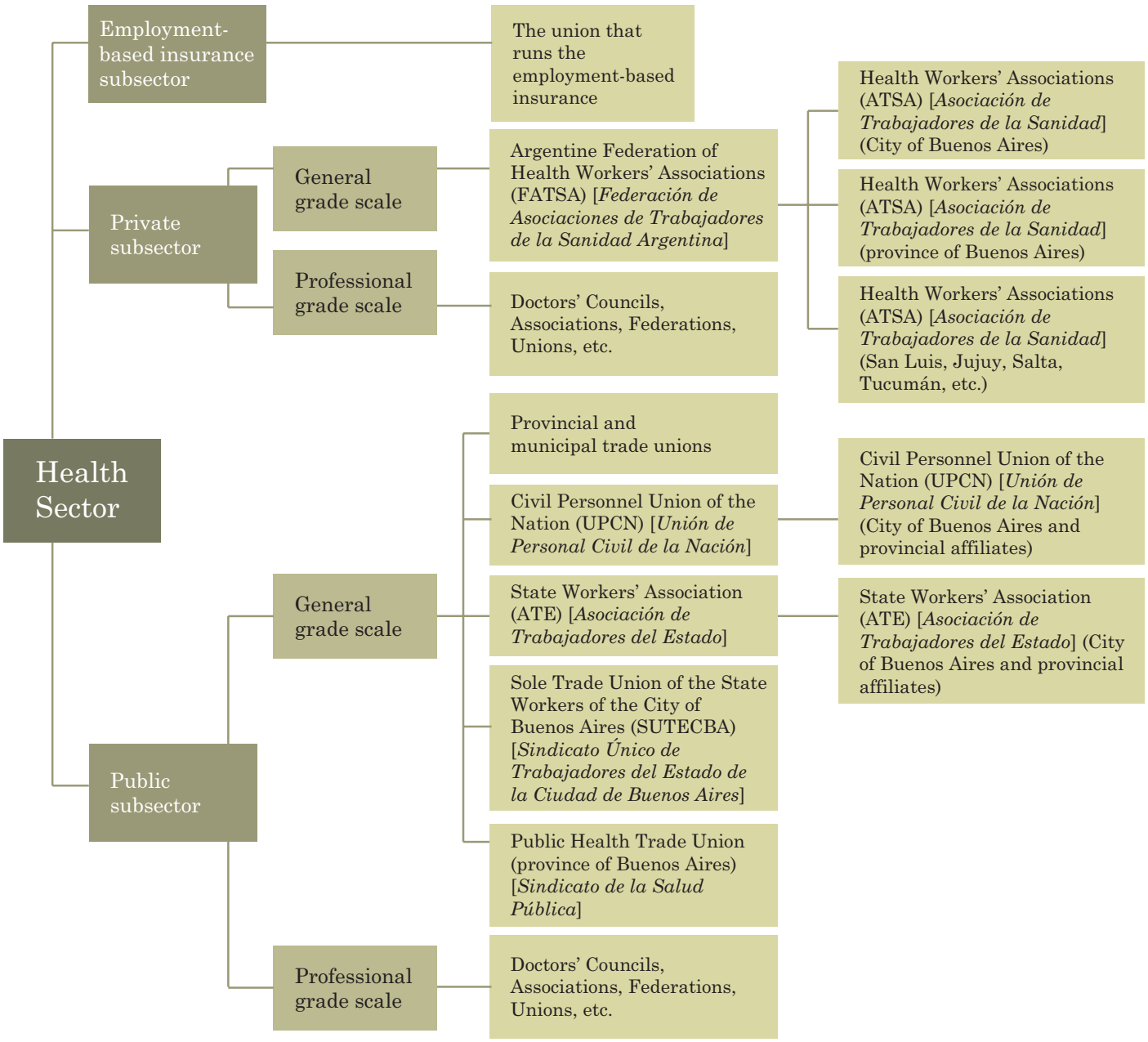

Figure 4. Trade union representation within the public sector. Argentina, 2014.

Source: Own elaboration.

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> *Most of the nurses in Argentina have two jobs, it would be hard to find a nurse with a single job* [...] *some of them work from Monday to Friday, and then Saturday, Sunday and on public holidays, they are called "day-off replacements"* [the second job is done on the "days off" or free days of the first job] *and the ones working night shifts have to work every other night. But there are some nurses working every other night in an institution and when they get out of that emergency shift they go to work in another hospital in the morning. So then you wonder, how do those nurses end their day? How can they take care of someone else?* (Program Director, private university, individual interview)

Here, the health sector fragmentation serves even to facilitate this situation, since simultaneous work in different subsectors or jurisdictions decreases potential incompatibilities while enabling and legitimating heavy workloads. As noted by a government officer of the Ministry of Health:

> *The system is prepared for moonlighting, that's the way it is, having two jobs happens everywhere and it is even structural...* [An ordinary pattern is that of] *a female nurse that has on the one hand a stable job which is generally performed in the public sector, with all the benefits offered by the public sector concerning leaves, and a job that is performed in the private sector* [...] *where she arranges the days-off and absences that she can use in the other job. Days-off and absences that may be used to work somewhere else or used because the nurse is just worn out.* (Government official of the Human Resources Area, Ministry of Health, individual interview)

DISCUSSION AND CONCLUSIONS

Throughout this article we have sought to show how the social devaluation of health care – with all its gender connotations – may be interpreted as a factor of utmost importance when it comes to describing the labor conditions in nursing. In fact, the care component of the occupation is closely related to traditional gender stereotypes that serve to associate specific nursing knowledge with such knowledge and abilities supposedly "inherent" to the female condition. The high permeability of this kind of discourse, even present in the narratives of those performing this profession, suggests the need for arduous political-institutional efforts to deconstruct these notions leading to the de-hierarchization of the work performed. In addition, at an institutional level, the social devaluation of care provided by nursing personnel is expressed, for instance, through the poor formal levels of qualifications required by the health system for these human resources, the confinement of the occupation to working schedules and schemes of "non-professional" workers of the health sector or their subordinate positions to medical personnel in everyday labor interactions, to name but a few of the indicators observed.

On the other hand, we have also explored how other factors – here we studied the health sector fragmentation – serve to reinforce, in this case, the "penalization" of care in the workplace. Even though the system fragmentation undoubtedly has an impact on all health occupations, it is those that are in a more vulnerable situation politically – as in the case of nursing – that are relatively more affected. Hence, as far as vulnerable labor conditions are concerned, the decentralization of the system marks different work experiences according to the type of insertion, a situation that hinders the possibility of articulating labor demands. This possibility is also affected by the significant trade union disparity of this labor group: apart from the trade union division of nursing with respect to medical occupations, we should also add the proliferation of trade union representations depending on the insertion subsector, as well as the different jurisdictions to which the personnel reports within the public subsector.

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In fact, the lack of political power in this occupation – due to the fact that its tasks are pigeonholed as traditional gender stereotypes, the occupation is performed within a doctor-hegemonic health system, or a fragmented health system leading to salary disparity – then appears as a focal point to be addressed in order to improve the labor conditions of this occupation.

Based on this very vulnerable positioning, government interventions precisely play an essential role in improving nursing labor conditions. In this sense, we consider it pertinent to finish this article reviewing some focal points of a set of legislative initiatives regarding nursing which have emerged from the political power over the last years. They encompass a series of bills that tend to touch upon themes relative to many of the key issues surrounding this occupation and that have been identified throughout this work.

On the one hand, most of these bills favor the declaration of a national emergency of nursing human resources, suggesting different options to implement a national training program for the occupation.[31,32,33,34,35,36,37] These types of policies would aim at not only relieving the quantitative and qualitative deficit of human resources but also at empowering nurses by giving them educational credentials that back up the value of their specific knowledge. In this sense, there are interesting international experiences that show different ways to move forward in the matter. Brazil, for instance, is a country that amid a crisis regarding nursing personnel qualifications implemented a national program of hierarchization of the occupation through the Training Project of Nursing Workers (PROFAE) [*Projeto de Profissionalização dos Trabalhadores da Área de Enfermagem*], in effect since the year 2000 and funded by the Inter-American Development Bank and the National Treasury. Based in the Ministry of Health, this project took on a national training program for workers who were already in the nursing practice in all the states of Brazil. This intervention resulted in a mass process of staff reconversion in the lower qualification strata, mainly from the empirical to the assistant level and from the assistant to the technical level.[16,38] The European case provides an interesting example with respect to fostering university training in nursing. Upon the creation of the European Higher Education Area (EHEA), the goal was to harmonize the different university educational systems of the European Union in ordeer to facilitate professional and student mobility, and scientific cooperation in general. Nursing, in particular, experienced important changes, since the adhesion to the EHEA promoted stricter requirements of educational credentials to take part in the opportunities offered by the program. In this sense, the EHEA promoted the expansion of the delivery of the academic program in university spaces, generating a slow but progressive tendency towards the undergraduate university degree to practice the occupation, as well as postgraduate studies in the discipline.[15] The valorization of the occupation through its hierarchization in a university context is a subject of great importance, since nursing is positioned in a more attractive place in terms of career choice, in an international context in which the scarcity of human resources in nursing – and particularly of qualified staff – is a recurring problem.

On the other hand, the national bills at play tend to coincide regarding the need to establish nursing activity as unhealthy work in all the areas where it is performed with the aim of determining special leaves, an early and special retirement scheme, and a maximum of workday hours.[39,40,41,42] This point also appears to be a core issue as evidenced in the problems mentioned by the interviewees, mainly in relation to the widespread cases of job stress. Nevertheless, as clearly shown by the situation of the nursing personnel in the province of Buenos Aires – where this type of policy is gradually being implemented – if these measures are not coupled with salary increases, the objective to relieve the workload of the occupation could be undermined. In this sense, a reduction of the hourly load while earning low salaries would perpetuate and even intensify the already existing moonlighting cases.

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The previous point leads us to a third and last core issue that is worth mentioning, which consists of the proposal to establish minimum remunerations for the occupation much higher than the current ones (measured in terms of a certain amount of national minimum wages).[41] An interesting aspect of this proposal lies in its national scope, which would put forward a possible solution to the issue of the profound salary fragmentation of the occupation, as well as the fact that higher levels of training would be strongly rewarded in salary terms, constituting an incentive for the professionalization of the occupation.

Clearly, any of these proposals (which, of course, are not aimed at exhausting the spectrum of possible initiatives oriented toward the occupation) do not amount to a merely technical challenge but also, and fundamentally, a political one. These bills imply challenging schemes which are deeply established and rooted regarding the allocation of resources (material, but also symbolic) and, as a result, power relations. Hence, the possibility of implementing any of these (or other) proposals strongly depends, on the one hand, on conscience, will and the strategies that may occur in governmental decision-making domains. And, on the other hand, an ideal scenario would include a strong influence of the nursing personnel itself by generating initiatives and political pressure. The introduction of demands on the public agenda by the social agents involved is key, and it amounts to the need to build political power on the part of all nurses as a group for the purpose of encouraging these initiatives in pursuit of their own interests.[43] In this sense, the specific gains that may be achieved when it comes to boosting the training level of these workers in the mid- and long-term constitute a strategic factor. Leveling the training of nurses according to a higher bar would generate elements and arguments to demand a place in the professional structures of the health sector as well as stimulating better articulation among its organizations, contributing to a better political (and, as a consequence, labor) positioning of the occupation.

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ENDNOTES

[[a] The Buenos Aires Metropolitan Area (AMBA) [*Área Metropolitana de Buenos Aires*] is made up of municipalities and neighborhoods of the City of Buenos Aires and the conurbation in the province of Buenos Aires [known as the "*conurbano*" in Spanish], characterized as the urban concentration with the highest population density of Argentina (it comprises about 30% of the total population). Its territory has large urban agglomerations, where the wealthiest sectors of Argentina live together with populations in conditions of structural poverty. These inequalities present a pattern in terms of territorial distribution since those sectors with higher incomes tend to concentrate in the Autonomous City of Buenos Aires, while the sectors with low and medium-low income prevail in the suburbs. The exception is, on the one hand, the northern belt of the suburbs – which gathers the well-off sectors that live in the suburbs of the Autonomous City of Buenos Aires – and, on the other hand, the

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number of private, isolated and scattered urbanizations, which over the last decades have begun to proliferate throughout this territory. As a correlate to this unequal pattern of territorial distribution of wealth, the Buenos Aires Metropolitan Area encompasses large differences between territories in terms of coverage, complexity and quality of the health services offerings, in some cases larger than those observed among the provinces.[12] In this context, the Autonomous City of Buenos Aires is particularly different from the suburbs, since it concentrates the largest part of the health services and human resources structure of the Buenos Aires Metropolitan Area.[13]

[b] Resolution 1480/2011 issued by the Ministry of Health establishes that research in this field requires, in addition to the informed consent of all the participants, the initial evaluation of the project by a Committee of Ethics in Research. Nevertheless, the project in which this work is included was not subject to this procedure since it was not requested by the National Agency for Science and Technology Promotion, the entity which approved and sponsored the research.

[c] Since 2013 a labor scheme regarding unhealthy work has been in force, which establishes the passage from 48 to 36 weekly work hours with no salary reduction (amendment to Section 26, Act No. 10430). In 2014 the possibility of early retirement at the age of 50 with 25 years of service was added. Nevertheless, the application of the latter benefit is not automatic, but rather starting from the year 2014 the reduction of the retirement age and the contributions required is progressively lowered until the year 2018, when the new regulations will be in full force and effect.

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