Aspects of precarity among employees of the Polish healthcare system

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ABSTRACT

Introduction: Authors analyze aspects of social stratification proposed by Guy Standing with respect to key medical professions performing work in Polish publicly funded medical entities.
Purpose: The aim of the paper is to assess how health care providers can be assigned to particular classes and if the precarity phenomenon occurs in their work environment.
Materials and methods: An overview of statistical data was made on how health care providers performed their work in years 2005- 2014 and the pay rates in 2014.
Results: The vast majority of medical staff employed on the basis of civil law contracts were doctors. A smaller number of civil law contracts has been concluded by nurses and midwives. The number of nurses performing work on this kind of contracts has increased considerably since 2005 and in 2014 there were 10.27% of them. A senior nurse earned PLN 2,600.00. It was very small in comparision with average gross remuneration in the national economy in 2014 amounted to PLN 3,783.46. Unemployment existed in population of nurses was 2.3–2.8%. It is called tyhe natural unemployment.
Conclusions: It was found that precarity phenomena occur in the Polish healthcare system although none of the professions met all the criteria attributed to the precariat.
Keywords: Precariat, public healthcare, healthcare occupations

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INTRODUCTION

Precariat

In the 70s of the previous century Marc Lalonde presented the impact of various factors on the health condition. This classic paradigm is an excellent point of departure to consider the influence of various factors in temporal dimension. The changing reality modifies the impact of particular determinants on the public health condition. Medical personnel plays a specific role in the assessment of the health condition. Health care providers are members of society heavily influenced by the work environment. Societal changes modify working conditions as well as employees' social and economic status.

One of the premises in the National Health Programme (Narodowy Program Zdrowia), societal impact on the health condition is recognized by the Ministry of Health of the Republic of Poland [1]. Liberal and global economy necessitates changes that lead to creation of new classes, strata or social groups. The changes are reflected in research and scientific descriptions. Professor Guy Standing introduced the term 'precariat' to social sciences [2]. It is a neologism composed of the following Latinate words: '*caritas*' meaning 'mercy', '*precarius*' meaning 'requested, granted at the strong request' [3], '*proletariat*' denoting 'a social class that consists of hired workers, especially industrial workers' or denoting 'the poorest stratum of society' [4]. In Standing's view it is a new social class: '*precariat-precarious workers'*, a class that is different from the proletariat but shares many of its characteristics.

The precariat is not the only class that Standing identifies. However, his classification is markedly different from the classifications proposed by other classical sociologists. For example, Karol Marx based its theory on the criterion of ownership of means of production, coming up with the idea of proletariat. Standing drew upon Marx's idea, coining the term 'precariat'. Max Weber sees social classes in a more complicated way, taking into account such characteristics as prestige, wealth and power. Also William Werner's classification into the classes is worth mentioning as it is based on the economic status and related social prestige. He categorizes the society into the upper, middle and lower class and identifies several social subgroups. Adaptation of the concepts of classes to the Polish reality has been proposed by Henryk Domański [5].

Poland is not a country with a fully-fledged market economy. However, many social phenomena typical of this type of economy are already present. In his book Guy Standing proposes seven social classes [6]. '*Elite*' disposes of enormous financial resources and its members are mentioned in Forbes ranking. '*Salariat*' encompasses full-timers with permanent jobs that provide for disabilty and old age. '*Proficiants*' is a portmanteau word that blends 'professional' and 'technician'. The word describes people with narrow specializations capable of earning high income as consultants or contractors. Classic '*working class*' is composed of hired workers that earn a living off stable jobs. '*Precariat*' is underneath the fourth described classes. The remaining social classes are '*the unemployed*', and '*the detached*'. The former one is composed of people who are dependent on social services because they have been out of work for a long time. The latter one is lumpenproletariat which is a class of the lowest social standing made up of ''declassed people, living unstable lives in penury and holding unspecified, odd jobs'' [7].

Extensively described in the English literature, the precariat phenomenon refers to liberal economy of highly developed countries. Poland is still an aspiring country. Poland's economy has been going from strength to strength. Also there is improvement in the economic situation of the Polish society. Data and analysis are to be found in the paper entitled 'Social Diagnosis 2015'. Although employment is rising, we still encounter many disturbing phenomena. In 2015 unemployment stood at 7.7% yet at a cost of, inter alia, employment instability. As far as forms of employment are concerned, there is a huge percentage of unstable temporary contracts. 'They made up nearly 30% of all workers in economy. The segmentation of the labour market concerns the permanent division of labour market into a better and a worse part which encompasses people who constantly get unstable and low-paid jobs''[8].

Public moods reflect the situation. In March 2015 the Precariat Congress took place in Warsaw. One could read the following information on the Internet website of the Congress: 'At least 1.6 million Poles have junk contracts, i.e. civil law contracts. Without entitlements, with no right to leave or overtime pay. Even greater number of people have employment contracts but their life is not easy either. Being low-earners, their salary is sufficient to satisfy only basic needs or is not able to satisfy them at all. We are deprived of stability and security' [9]. The characteristic features of the precariat are as follows:

1. Unspecified job positions
2. No permament contracts
3. No employment rights such as
    a. regular working hours
    b. pay for overtime work
    c. right to leave
4. No opportunities to develop professionally
5. Periods of unemployment
6. Unstable social situation, i.e.:
    a. no fixed income
    b. no creditworthiness

c. no opportunities to achieve their ambitions

7. Difficulties to maintain mental health, e.g.
   a. professional burnout
   b. inadequate engagement in the performed work
   c. marital and family crisis situations

The social class of the precariat is not uniform. Three groups may be distinguished. 'The members of the first one are born into the poorest families and come from tiny towns, standing a slim chance of good education and professional development. Other members of this group have lost permanent employment due to age or restructuring. The second precariat group is made of young educated people participating in constantly unpaid or low-paid internships as well as professionals living off casual jobs and temporary contracts. The third precariat group includes, inter alia, migrants, the disabled or the sentenced' [2].

Although the description of this social group results from the critical attitude to liberal (neoliberal) economy it shows objective problems related to specific manner of performing work. The phenomena of the precariat employment policy are also present in medical entities [10]. They constitute part of deregulatory employment policy.

Forms of employment in public healthcare entities in Poland

Diverse as they are, employment in the healthcare sector is related to the financial standing of the entity which, in turn, is influenced by sources of income, organizational structure and management style. Multiple transformations of the healthcare system have led to the creation of medical entities with various legal forms and different ways of paying for medical services. This segmentation was reinforced by the provisions of the Law of 2011 on Medical Activity [11]. To analyze the precariat phenomenon in the healthcare system it is essential that two separate sources of funding of medical services be considered. Thus, one may speak of the public healthcare system, currently sustained by medical insurance contributions that are supplemented by the state budget and the private healthcare system financed directly by the patient.

Public healthcare services may be provided by different medical entities. One of them are independent public healthcare institutions (in Polish: SP ZOZ) which are owned by the state authorities as well as units of self-government (in Polish: JST). Another one are non-public healthcare institutions (in Polish: NZOZ) set up in accordance with the provisions of the Law on Healthcare Insitutions which have private owners and varied legal status and are supported by public funds [12]. In the public sector medical services may be provided by different practices run by either doctors or nurses as well as commercial law companies. Legally restricted access to private sources of funding is an essential feature of publicly funded provision of medical services (e.g. private hospitals). The process of transforming the Polish healthcare system started in 2016. The way of financing the system and medical entities has not changed till the date on which the article was submitted for publication.

This diversity is additionally reinforced by different forms of employment [13], namely employment contracts and civil law contracts. Employment contracts are governed by the provisions of the Labour Code. They are a stable form of employment. Various vocational groups are employed in such a way. Civil law contracts are concluded with providers of medical services. Our considerations are limited to contracts with practices that are subcontractors of medical services, i.e. doctors, nurses and midwives. In Poland subcontractors conclude contracts for a fixed period of several years, which is a short time span. The burden of civil liability for the performed services is on the subcontractors. Two types of pay rates may be distinguished. The first type of rate is similar to the rate obtained by employees who hold the equivalent job position. Such rates are included in majority of contracts. It is worth mentioning that pay rates of publicly-funded healthcare entitites that are legal persons and manage their finances independently are specified in the collective labour agreements or remuneration rules. In practice the rates do not differ much from rates specified by the Ministry of Health for budgetary units [14].

The aim of the paper is to assess the Polish healthcare system in the light of Guy Standing's theory, which proposes a new classification into social groups before the changes of the system introduced in 2016. A special emphasis was placed on whether each group qualifies as the precariat.

MATERIALS AND METODS

There was made an overview of statistical data from Statistical Bulletin of the Polish Ministry of Health (2005-2014), on ways the three categories of health care providers, namely doctors, nurses and midwives, performed their work in years 2005 – 2014. On the basis of the official data their remuneration was established. Next, they were qualified to classses proposed by Guy Standing.

RESULTS

In years between 2005 and 2014 the vast majority of medical staff employed on the basis of civil law contracts were doctors. Their number is on the increase, making up over 47.94% in 2014. A

smaller number of civil law contracts has been concluded by nurses and midwives. However, the number of nurses performing work on the basis of civil law contracts has increased considerably since 2005 and in 2014 there were 10.27% of them. In the surveyed period the number of contracts with midwives has fluctuated, currently accounting for 8.76%. Detailed data are contained in the attached Table 1.

Table 1. Medical staff working in hospitals in the years 2005-2014

Years	*Doctors*		*Nurses*		*Midwives*	
	on the basis of the employment contract	*on the basis of the civil law contract*	*on the basis of the employment contract*	*on the basis of the civil law contract*	*on the basis of the employment contract*	*on the basis of the civil law contract*
2005	18 406	8 894	34 188	4 917	4 801	1 611
2006	17 886	9 847	34 029	5 114	4 694	1 769
2007	44 093	16 036	115 889	3 870	15 388	433
2008	42 963	20 590	117 344	4 929	15 660	611
2009	42 920	23 444	117 688	5 855	15 695	688
2010	43 112	25 920	118 450	7 152	15 804	781
2011	43 167	30 029	120 614	8 056	15 899	879
2012	43 119	34 443	120 509	10 684	15 754	1 096
2013	42 873	35 958	119 559	12 001	15 621	744
2014	41 893	38 572	118 890	13 616	15 649	1 504

Source: Authors' own elaboration based on Biuletyn Statystyczny Ministerstwa Zdrowia (2006), Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa, pp. 34-37; *Biuletyn Statystyczny Ministerstwa Zdrowia* (2007), Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa, pp. 35-38; *Biuletyn Statystyczny Ministerstwa Zdrowia* (2008), Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa, pp. 34,35; *Biuletyn Statystyczny Ministerstwa Zdrowia* (2009), Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa, pp. 39,40; *Biuletyn Statystyczny Ministerstwa Zdrowia* (2011), Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa, pp. 79,81; *Biuletyn Statystyczny Ministerstwa Zdrowia* (2012), Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa, pp. 71,73; *Biuletyn Statystyczny Ministerstwa Zdrowia* (2013), Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa, pp. 59,60; *Biuletyn Statystyczny Ministerstwa Zdrowia* (2014), Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa, pp. 59, 60; *Biuletyn Statystyczny Ministerstwa Zdrowia* (2015), Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa, pp. 59, 61.

Specialist doctor (senior assistant) earns PLN 3,950.00 gross in accordance with XIX pay scale. Nurses or midwives may be employed as assistants or senior assistants if they hold a Master's degree diploma. However, most of them are employed in lower-ranking positions. A senior nurse may earn PLN 2,600.00 in accordance with XIV pay scale, whereas a specialist nurse's basic remuneration comes to PLN 2,850.00 in accordance with XV pay scale. People holding managerial positions earn higher salaries and managerial salary supplements. Contractual pay is established by adding basic remuneration and social security contributions, i.e. contributions to old age pension, disability pension, health and accident contributions. It all comes to respectively PLN 4,769.23 and PLN 3,441.09 respectively. The study of the Central Statistics Office data reveals that the average gross remuneration in the national economy in 2014 amounted to PLN 3,783.46. In addition, seniority allowance and position-related allowance and in case of doctors an equivalent of opt-out duty hours is awarded as well. Usually there is an inherent obligation to work within the current working time. Pay in civil law contracts is specified in a more flexible way. It may be based on hourly basis or currently received remuneration. The employer tends to reduce labour costs. Pay in civil law contracts may be dependent on the procedures performed without adhering to any specific time regime but the doctor is under an obligation to take care of the patient and be immediately available if the patient' condition suddenly worsens. This type of pay construct makes it possible to earn more at a cost of being costantly on call. The above considerations reveal that the remuneration in the precariat groups varies. However, if workers want social security they must take care of it themselves. It can be concluded from the above analysis that there are huge financial disparities within this group. Upon subtracting necessary sums, the pay is without paid leave, overtime, etc. Highly paid workers may be tempted to spend or consume the earned income. The income obtained from low-paid jobs is immediately spent as a matter of course.

In the second group of civil law contracts the pay is market-adjusted. Such contracts are

concluded with representatives of deficient, not necessarily narrow specializations. The providers may earn up to several thousands zlotys (surgerons, for example).

The low rate of unemployment amoub nurses was found.

DISCUSSION

In-depth analysis of reasons for the situation is beyond the scope of this paper. However, it may be stated unequivocally that one of the most important factors influencing this situation is the fact that remuneration costs constitute a considerable percentage of the costs of operational activities of medical entities and their reduction is achieved by civil law contracts because such contracts reduce the employer's social security costs.

The conducted analysis makes it possible to systematize forms of employment in the healthcare establishments in three classes according to Standing. Low-paid '*working class*' and well-paid '*salariat*' have stable working conditions. '*Proficiants*' are specialists employed on the basis civil law contracts with market-adjusted pay.

There is also a huge group of workers all of whom or a vast majority of whom qualify as the 'precariat'. People who perform work on the basis of civil law contracts with rates which are a direct transposition of pay conditions usually fall within the precariat category. They perform ancillary work and services (house-keeping, laundry, protection of premises). These workers are usually hired by subcontractors. Having permanent stable jobs, they qualify as the 'workers' class'. If they are on civil law contracts they exhibit the characteristics of the precariat in full.

How should we classify people who provide medical services and are employed on the basis of fixed-term civil law contracts? If their pay directly derives from the pay obtained by employment contract workers, then, as far as nurses and midwives are concerned, we can talk of a group similar to the 'precariat' category. At present they are not threatened by unemployment but they meet the other 'precariat' criteria.

The precarity phenomenon on the Polish labour market was paid attention to by Szarfenberg [13]. It is also present in medical entities. It is a side effect of managing the system subject to continuous financial shortages. On one hand, application of precariat practices makes it possible to lower operating costs of enterprises, on the other hand, it poses threats resulting from unstable working conditions.

On one hand, establishment's operating costs are reduced due to the precariat in medical entities, on the other hand, unstable working conditions may pose a threat. In the healthcare sector principle of allowable number of working hours may be ignored. It is advantageous to the employer and makes good the deficit in some specializations. One person can deal with the work that should be specified in a few employment contracts. Precariat workers can obtain high income by lengthening working hours. Civil law contracts are concluded with a couple of entities. This work system harms the employee as it induces a lot of stress [15]. The cumulative effect of these factors overlaps with negative impact of working conditions typical of hospital settings, constituting a threat to medical entities. Doctors, nurses and midwives working within this system have neither time nor means to improve qualifications. Consequently, the quality of provided services is adversely affected. This aspect is often overlooked by the managerial staff forced to cut costs and make short-time plans only.

It seems that with the passage of time the precariat phenomenon should disappear from the doctor's profession in Poland. In 2014 in Poland 230.7 doctors had to handle 100,000.00 inhabitants. It is the next to last place in Europe. Austria has the best ratio of 504.9 doctors and neighbouring Lithuania has 430 doctors [16]. The latest domestic data collected in order to make a map of health needs reveal that doctors are in high demand. Shortage of doctors make it possible to negotiate better remuneration and move up to the '*proficiants*' class that works on the basis of civil law contracts or to '*salariat*' class that works on the basis of employment contracts and obtains higher pay. Thus an opportunity opens up to leave the '*precariat'* class. The same applies to the professional situation of nurses. Currently nurses are in high demand. The document entitled 'Map of health needs in hospital treatment in Poland' states that 'the analysis of employment pattern of nurses and midwives brings into relief the need to quickly increase the number of nurses and midwives by employing more younger staff'[17]. Such situation should help nurses leave the precariat class. However, the barriers result from low financial outlays and limitations to obtain revenue by medical entities that cooperate with the National Health Fund. The National Health Fund limits the number of services regardless of real demand or providers' possibilities.

Unemployment exists only in population of nurses. "The rate of unemployment of 2.3–2.8% is caused by economic immigration on the one hand and the natural unemployment on the other, as a result of the lack of jobs in the region"[18].

Presenting the precariat phenomenon in the Polish healthcare system, the authors of the paper are aware of changes proposed by the government authorities currently in power. The changes concern employment law (minimum wage, obligatory

contributions to be paid on civil law contracts, etc.). Such solutions may be beneficial to the employee. However, as usual, the problem resides in financing the transformations. The precariat phenomenon in the healthcare system may be influenced by a way in which medical services are to be financed. Not until new laws enter into force and the upcoming health care reform sets in, will it be possible to estimate the holistic effect of proposed changes on medical staff.

CONCLUSIONS

The current Polish healthcare system may be said to include a few social classes according to Guy Standing's classification. The presence of the precariat phenomenon was noted. However, none of the medical healthcare providers fully matched the precariat category.

Conflicts of interests

There are no conflicts of interests regarding the publication of this article.

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