



Nurses' Labor Conditions, Gender, and the Value of Care Work in Post-Neoliberal El Salvador

Critical Sociology

1–15

© The Author(s) 2016

Reprints and permissions:

sagepub.co.uk/journalsPermissions.nav

DOI: 10.1177/0896920516675203

crs.sagepub.com



Lisa Kowalchuk

University of Guelph, Canada

Abstract

Neoliberal cut-backs in health-care spending have had numerous negative impacts on nurses, but we know less about how they fare when governments move from neoliberal austerity to reinvestment in their health-care systems. El Salvador is an apt case to examine for how a post-neoliberal health-care reform, launched in 2010 by the newly elected FMLN government, addresses the deterioration in nurses' work conditions caused by austerity policies. Based mainly on focus groups, interviews and participant observation conducted in the first three years of the reform's implementation, the analysis finds important strides for nurses, especially in increased hiring in the expanded components of public health-care, and the reduction of labor precarity in formal employment. But several problems continue to imperil nurses' well-being, reflecting, in part, a persistent devaluation of the care work that is performed mainly by women.

Keywords

care work, Central America, gender, health-care, nurses, post-neoliberalism, sociology

Introduction

Nursing in our country ... is like a little elastic band. The rubber in fact has a tension and they stretch it and stretch it, but they keep stretching it so much now that I believe nursing is now on the border of its maximum expression. But because 'keep putting up with it and don't break, *hijita*' they keep stretching you, and the moment comes when you – but you just keep going. (Focus group participant Haydee, nurse with 30 years' experience in the public sector)

The work-related well-being of nurses reflects how care work, performed largely by women, is valued by employers and the broader society. Emerging from a 12-year civil war in 1992, El Salvador was governed for the next 17 years by the highly conservative National Republican

Corresponding author:

Lisa Kowalchuk, Department of Sociology and Anthropology, University of Guelph, 50 Stone Road East, Guelph, ON N1G 2W1 Canada.

Email: lkowalch@uoguelph.ca

Alliance (ARENA). ARENA needed no cajoling by international financial institutes to embrace their recommended reductions of the state's role in social programs. Health-care was not exempt from this. Contraction of state spending deeply affected services as well as the conditions of the personnel. But more recently, El Salvador is also one of several Latin American countries in which left-of-center parties were elected to power with plans to reverse the neoliberal reforms of their predecessors. Upon taking office in 2009, the former Marxist armed insurgent force, the Farabundo Martí National Liberation Front (FMLN), embarked on an expansive health-care reform that prioritized primary, preventive services.

This paper raises two main questions. Firstly, how were nurses¹ affected by the neoliberal measures of the ARENA government (1989–2009)? Secondly, has the FMLN government addressed the more deleterious of those impacts, and does this reflect any positive reevaluation of nurses' work? In other words, to what extent are care work and the conditions of mostly women care workers prioritized by a left-of-center government that attains power on the promise of treating health as a fundamental human right? While the effects of neoliberal policies on nurses have been studied fairly extensively in affluent countries, less scholarly attention has been paid to their situation in the less developed countries (Squires, 2007; Squires and Juarez, 2012). Fewer studies examine how nurses fare when governments change course to restore investment in health-care workforces (Heitlinger, 2003).

Based on qualitative data collected through interviews, focus groups and participant observation, the paper will show that austerity policies in health-care undermined Salvadoran nurses' physical, psychological and social well-being. The FMLN government's health-care reforms, along with a series of new policies toward health workers, have brought important improvements. But problems remain in the realms of workload, employment precarity, and remuneration, some of which, I argue, reflect the persistence of a gendered devaluation of care work.

Gender, Health-Care Austerity, and the Value of Care Work

A gendered lens is imperative for analyzing nurses' working conditions in any context. Women make up at least 90% of the nursing workforce in most countries. As well, the value that employers and the broader society place on care work generally is affected by essentialist ideas about gender and nurturing. According to the 'devaluation of care' thesis, care occupations are economically under-rewarded because those who do care work are assumed to be enacting natural qualities, not a set of learned skills and specialized knowledge (England et al., 2002). A 'wage penalty' for care workers has been found in a variety of different countries including several in the developing world (Budig and Misra, 2010; England et al., 2002; Lund, 2008). While some discuss this penalty as a ubiquitous strategy for keeping the status of women low (Hochschild, 2009), others theorize that it varies with the policy environment (Boris and Klein, 2012) and other socio-political conditions. Indeed, the extent of the wage penalty is found to be less severe 'where income inequality is low, union density is high, the public sector is large, and public spending on care is high' (Budig and Misra, 2010). Certainly El Salvador has been expanding and prioritizing public services since 2009.

Another reason we need a gendered lens for these questions is that nursing as an occupation was crucially shaped by its origins in the hospital setting where it was subordinate to medicine. This early history of being controlled by male physicians who devalued their work has left a lasting legacy (Ashley, 1976; Reverby, 1987, 2002). Though there is a dearth of scholarship on how nursing in Latin America (and the developing world in general) originated and evolved, Squires' study of Mexico (2007) finds circumstances similar to those in the Global North – especially suppressed salaries and domination by doctors – have made it a struggle to attain recognition as a profession.

As an orientation to policy that influences how care work is valued, neoliberalism reinforces gender inequalities both on the receiving and delivering end of care services. Across the developing world, health-care workers in general experienced devaluation under neoliberal cost-cutting that governments began to implement in the mid-to-late 1980s, ostensibly in response to widespread debt crisis. Morale was greatly damaged by fallen real salaries, shortages of the materials that made it possible to do their jobs well, a decline in incentives for excellence, and a greater physician control over health policy-making to the detriment of other health-care occupations (Homedes and Ugalde, 2005; Laurell, 1991; Segall, 2000; Ugalde and Homedes, 2005). For nursing in particular, health-care austerity in Latin America and other developing regions caused work speed-up by generating staff and equipment shortages (Abramovitz and Zelnick, 2010; Guevara and Mendias, 2002), more paperwork, and new ‘bureaucratic tasks for which nurses were not trained’ (Homedes and Ugalde, 2005: 9). By leaving far less time for contact with patients, these changes have left nurses frustrated and demoralized (Homedes and Ugalde, 2005). Reforms in Latin America also flexibilized hiring in the form of more part-time and temporary positions (Guevara and Mendias, 2002). Across the developing world, these reforms hit nurses harder than doctors, many of whom have private practice as an escape valve (Mackintosh and Tibandebage, 2006).

The (de)valuation of care work should be thought of as a multi-dimensional phenomenon (Bigo, 2010), encompassing not just salaries but also investment in adequate staffing, and non-monetary forms of recognition of nurses’ contributions to population wellness. The outcomes of neoliberalism in health-care described above, then, reflect an implicit devaluation of nurses’ work, implicitly reinforcing their taken-for-granted status, and fueling the expectation that they will simply absorb additional demands arising from staffing deficits in and beyond nursing. Neoliberal planners count on ‘the role of normative femininity in the maintenance of [nurses’ self-] exploitation’ and on nurses living up to their ‘traditional caring responsibilities as well as to professional commitments,’ whereby they ‘cover for the organization’ (Selberg, 2013: 23, 9).

A question that has received far less attention in the literature is what happens to the valuation of nurses’ work under the reversal of austerity reforms. What all left-of-center governments in Latin America have in common is a rejection of neoliberal ideology (Arditi, 2010) and a commitment, at least in principle, to universal citizenship (Beasley-Murray et al., 2010). But it cannot be assumed that a higher valuation of care work will flow automatically from such policy shifts. For policy-makers accustomed to taking care work for granted, nurses may be seen as capable of absorbing any revitalized demand on public health-care facilities. As well, a prolonged period of austerity creates substantial problems and needs in multiple realms of public health-care. These issues make El Salvador an important setting in which to examine the impact of both neoliberal and post-neoliberal policy shifts.

Health-care Policy Shifts in El Salvador: From Austerity to Expansive Reform

Starting in the 1980s, the World Bank and other Washington Consensus institutions moved to transplant the kinds of neoliberal reforms begun in affluent countries to the health-care systems of developing nations (Segall, 2000).² Cutbacks in state spending were to be followed by reforms that would accord a greater role to private enterprise in health-care and decentralize administration, among other goals (Muntaner et al., 2006; Segall, 2000). The international financial institutions that pushed social spending reduction on lower income countries, and the governments that complied with their aid conditionalities and advice, took advantage of economic crises to redirect societal resources toward debt reduction (Laurell, 1991; Homedes and Ugalde, 2005).

Relative to most of Latin America, neoliberal reform efforts in health-care were delayed in El Salvador by a civil war that lasted from 1990 to 1992. Ultimately, privatization was staved off by union and social movement resistance in the early 2000s. But as elsewhere in the region, even without significant structural overhaul, the cutbacks greatly eroded service quality and conditions for personnel. By 1995 ARENA had cut health-care spending to 2.46% of GDP,³ one of the lowest levels in the Americas. The largest part of the public system consists of the state-funded hospitals, clinics and specialized facilities that are mostly under the auspices of the Ministry of Health (MINSAL). ARENA's spending cuts in MINSAL, the majority of whose patients are from lower- and lowest-income groups, affected services, staff, and inventories of needed medicines and supplies in clinics and hospitals. Community and rural clinics kept sporadic and inconvenient hours of operation. User fees introduced for a vast range of appointments, procedures and materials were a further impediment for many to access services (Homedes et al., 2000).

The Salvadoran Social Security Institute (ISSS), which serves people ensured through formal sector jobs (about 15% of the population), is also considered part of the public system because it receives some state support. More of its funding, though, comes from employee and employer contributions. Service quality in the ISSS has long reflected a greater per capita resource endowment than the MINSAL facilities. The ARENA government contracted out an increasing number of ISSS ancillary (non-medical) services to private firms during the 1990s. Following two major strikes by unionized health-care workers and doctors in 1999 and 2001–2, ARENA shelved plans to privatize ISSS medical services (Almeida, 2008).

ARENA's spending cuts continued through the first decade of the 2000s, however, encompassing the elimination of hundreds of full-time nursing positions in MINSAL facilities through the offer of early retirement severance. Though there are no official data on how many nursing positions were shed through this mechanism, news coverage from that time period suggests a figure in the hundreds (Galdámez, 2001; Huezco, 2002). A shortage of nurses is documented for the early 2010s; the density of nurses in the population, at 0.51 nurses per 1000, was far below the World Health Organization's critical threshold of 2.3 (Squires and Beltrán Sánchez, 2013: 24).

Alongside these cuts, several new forms of temporary contracts were introduced for nurses. The total number of impermanent positions increased across the public sector from about 1700 in 2000 to 2400 by 2009 (WHO, 2013). These contracts ranged in length from two months to a year, with the shorter-term ones lacking benefits. One-year contracts which encompassed even high-level managerial positions provided benefits but no merit- or seniority-based salary increase, while the *ad honórem* contract lacked both benefits and salary, essentially amounting to an unpaid internship.

After 20 years of ARENA government, a left-of-center party was elected in 2009, a historic first. The FMLN's health reform, outlined in a blueprint document entitled 'Constructing Hope: Strategies and Recommendations for Health 2009–2014', aimed to provide the full range of health services to groups and areas long deprived of access to formal health-care. After immediately eliminating user fees in the MINSAL system, the FMLN embarked on expansive restructuring of the public system. Perhaps the most significant structural change was a new emphasis on primary, preventive care, particularly in rural and impoverished urban areas. The cornerstone of an expanded primary sector is the multi-disciplinary Community Health Team (*Equipo Comunitario de Salud* – ECOS), an entity that regularly visits communities to document individual and family health statuses. They also make follow-up house calls to those previously categorized as at risk, and attend patients at newly created ECOS locales. By mid-2015 the government had created 573 ECOS, each of which is attached to, and managed by, a Community Clinic for Family Health (UCSF). Though the UCSFs had previously existed, their numbers were expanded from 377 before 2009 to 747 by the end of 2014.

The FMLN government's health-care reform, along with other measures toward nurses and other MINSAL employees, address several aspects of the deterioration nurses endured under neoliberal policies. The new ECOS and UCSFs have required a substantial injection of health personnel, including nurses. For some ECOS visits, nurses are the only trained professionals sent out with the local health promoter. Furthermore, in its 2009–14 National Health Plan outlining the reform, the FMLN government explicitly committed to increasing the number of nursing hires in the public system. By 2014 MINSAL institutions employed 3100 nurses and 3930 *auxiliares*, an increase of 845 and 517, respectively, since 2009 (MINSAL, 2014).⁴ As well, the government began a phased conversion of annual contracts into permanent positions in 2010 for all categories of health workers (WHO, 2013). This entitles them to the salary increases and benefits stipulated under the Salary Law governing the public sector. A total of 5494 positions were converted by 2014 (MINSAL, 2014). The unpaid *ad honorem* contract was eliminated in 2013.⁵ Finally, addressing a longstanding nurses' grievance, the government called a halt to the sub-employment of professional nurses into *auxiliar* positions (key informant interview, 2013), a situation that, as a cost-saving strategy, had affected hundreds (Cáceres, 2010). My research addressed nurses' experience of both the first three years of this new regime in health-care, and the impacts of the previous decade's neoliberal reforms.

Methodology

The paper is based on data gathered during five field visits, each of several weeks duration, from 2010 through 2013. I conducted five focus groups a total of 32 participants. Four of the five groups consisted of working nurses, and a fifth was made up of students in their final year of the degree program. The semi-structured interviews with nurses numbered 37 in total, of which 10 were carried out by a Salvadoran assistant. Several of these interviewees were directors of nurse training programs at both public and private institutions. Added to these 37 were 10 interviews with experts on contextual issues such as recent health policy changes, labor law, and the post-secondary education system. In a final phase of data collection, I conducted ethnographic observation, essentially shadowing nurses during their shifts in five clinical settings within the MINSAL system.

Three Salvadoran assistants, two with deep knowledge of nursing and the health-care system, helped me to recruit interview and focus group participants. The criteria I asked them to use reflected the tenets of nonproportional quota sampling, in which the goal is to include 'a minimum number of cases belonging to the key categories' (Trochim, 2008). An initial field visit in 2010 informed the overarching categories and characteristics to represent in both the focus groups (except for the students) and interviews: public vs. private sector, type of workplace, employment status, and years in the profession. See Tables 1 and 2 for the characteristics of the groups and interviewees.

The focus groups were asked to discuss three main themes: the conditions and environment of their workplaces (which, in the students' case, referred to their practicums and other paid work experience), nurses' contributions to health-care and whether these are recognized, and how nurses can influence change. Though in the interviews with nurses I sought more specific biographical details, the same basic themes shaped those questions. The student group was additionally asked to reflect on employment expectations. Focus groups and interviews were audio-recorded and transcribed. All participants signed informed consent forms. The project received approval from the University of Guelph Research Ethics Board. For the ethnographic and photographic component, which took place in five clinical settings in the public system, I additionally obtained authorization from the Salvadoran Ministry of Health.

To analyze the data from the transcribed interviews and focus groups, I used NVivo to sort material according to themes, some of which were pre-established and derived from the literature,

Table 1. Focus group composition (n=32).

Employment		Sector				Status		Work Setting			Years Experience			
Focus Group	n	MINSAL	ISSS	Other public	Private	Full-time	Temp contract	Hospital	UCSF	Other	0 to 5	6 to 10	11 to 20	21 or more
1	9	9				9		6	4			1	1	7
2	5		5			5		4			1		3	1
3	3	3				1	2	3			2	1		
4	5			2	3	4	1	2		3	1	1		3
5	10	–	–	–	–	–	–	–	–	–	–	–	–	–
	32													

while others arose from patterns in the data. For the focus groups, I first read the transcriptions to make summaries of segments of the conversations, looking at how prompted and spontaneously emergent themes and topics were discussed (identifying, for example, patterns of different opinions or types of experiences). Three other data sources to mention are the Health Ministry's publicly accessible annual reports, observations of several assemblies of nurses convened by the National Nurses' Association (ANES), and other documents generated by government, news media, and Salvadoran nurse researchers.

Research on health-care systems in developing countries is sometimes conducted across linguistic, cultural, and even occupational divides (Squires and Juárez, 2012). In my case, language skills were strong due to having lived in El Salvador for over five years since 1991, mostly for research purposes, which included a focus on health-care policy. But to address gaps in my comprehension of nursing matters, which are amplified by linguistic and cultural differences, I drafted a lengthy summary report on my findings in Spanish for feedback from several high-level nurses and key informants. I also gave three formal presentations on the research to groups of nurses in El Salvador in 2013 and 2014. Innumerable informal conversations over the three years with a small number of key informants also shaped my understanding of the situation. The following three sections present findings focused primarily on MINSAL, since this is the sector most directly affected by the recent policy shifts.

Findings

Workload Intensification

Physically and mentally taxing workloads, alluded to in the opening quotation, were signaled in the focus groups as one of the most difficult aspects of nurses' work in the public system. Invariably this was linked to staffing deficits. Several nurses shared current figures on the nurse-patient ratios of specific units or for their institution as a whole. In the neonatal unit of the maternity hospital, for example, where the indicator should be about 1:6, typically there was one nurse for 12 or 14 patients. In the intermediate care unit, the number of newborns is often at twice the installed capacity. A highly placed senior nurse in another large third-level hospital estimated a 40% deficit of nursing staff. It was reported that in one of the UCSF clinics there is often one nurse in charge of 10 different areas of care, whereas the ideal, they said, is one nurse for every two general areas, and one for each specialized area.

Table 2. Demographic data for individual interviewees (n=37).

	Number	Percentage
Role or title by education		
Bachelor's degree	20	54
Non-degree professional	3	8
Tecnólogo	5	13
Técnico	1	2
Master's degree	1	2
Unknown	7	19
Job title		
Auxiliar (Nurse Technician)	2	5
Nurse	19	51
Teacher	5	13
Charge Nurse	6	16
Supervisor	3	8
Director of Nursing	2	5
Employment status		
Full-time	32	86
Temp	3	8
Temp + full time	2	5
Health-care sector		
Public (MINSAL and other Ministries)	30	81
ISSS	2	5
Private	2	5
Public and private	2	5
ISSS and private	1	2
Workplace type		
Hospital	14	38
UCSF	14	38
Hospital and nursing school/university	1	2
Nursing school/university	5	13
Other	3	8
Years in the profession		
Less than 5	4	11
5 to 9	3	8
10 to 19	9	24
20 to 29	15	40
30 or more	2	5
Unknown	4	11

Workload increase has both an extensive and intensive dimension, encompassing, in other words, the sheer amount of time one spends at work and one's physical and mental expenditure (Selberg, 2013). Unpaid overtime emerged in the focus groups as an example of the former. While in the MINSAL system nurses are theoretically compensated for overtime in the form of banked hours, in practice, their superiors usually do not give official approval for extra hours clocked to complete crucial tasks. One nurse in a public hospital calculated that over the course of a month, most of her colleagues were working without pay for the equivalent of four eight-hour shifts. This

is an experience they share with nurses in other countries where neoliberal spending cuts also generated short-staffing, making task completion harder within the shift (see Selberg, 2013).

Testifying to the embodied effects of an intensive workload increase is a recent study by nurses at El Salvador's National Maternity Hospital that documents an increase in work-related illness and injury, with respiratory infections, acute gastroenteritis, and cervico-lumbar problems the most common. The researchers see this as at least partly to blame for rising absenteeism in that hospital (Arévalo Flores et al., 2009). All of these conditions were mentioned by nurses in my study, along with high blood pressure, diabetes, and migraine headaches, as effects of work intensification. Though I considered negative patient outcomes of short-staffing too sensitive a topic to broach, it sometimes arose spontaneously in focus group discussions, suggesting that jeopardized patient welfare is a source of mental stress for nurses.

The participants' analysis left little doubt that the ARENA government's policy of shedding full-time nurses' positions a decade earlier played a decisive role in short-staffing. But several nurses interviewed in late 2013 reported that there had been no restoration of more reasonable nurse-patient ratios in hospitals and clinics. This suggests that the new nursing positions created since 2009 have gone to the new or expanded primary sector facilities. Furthermore, there were several accounts of hospital authorities recently attempting to increase the number of beds in a unit or to physically enlarge a unit without increasing staff. In this regard, one interviewee who was active in his hospital union stated:

We have always negotiated that all the new areas that they have opened, in order to open and expand them, they also need staff. If you say nothing, the authorities are going to demand and impose. They only think about expanding coverage [of the population] but they don't think of the staff that they need to do this.

Several participants felt that such attempts to augment nurses' work are underpinned by a gendered devaluation and non-recognition of what they do. In a focus group, one nurse with over 20 years' work and advocacy experience relayed an illustrative anecdote:

This morning in a meeting we had with the Ministry a hospital Director wanted to resolve the problem of excess demand on an Emergency Unit by adding one hospitalization bed in each of the other units. Someone said 'one bed is nothing' ... People said to him look, there are alternatives, other strategies ... For example let's talk about the way the doctors are evaluating hospitalized patients ... You know what the Director's response was? It's that look, it's very difficult to arrive at an arrangement with doctors in that sense. But the nurses, they can very well take on attending more patients to resolve the problem, and they can't tell the doctor to do their work better.

One aspect of workload intensity is having to assume tasks that are unrelated to nurses' formally defined roles. In Latin America, a word that has been coined to capture this reality is *todismo* – 'everything-ism'. Many non-nursing work obligations seemed linked to shortages in other occupational categories. A nurse employed in one of the prisons stated, 'We as nurses have to do the cleaning: sweeping, mopping, taking out the garbage, burning the garbage to keep the place clean.' Several nurses shared anecdotes of having to fix malfunctioning equipment.

Some participants also perceived this as gendered: they are seen as 'mothers' who can resolve everything, or as 'las *muchachas* (domestic servants) of the system'. And yet, as one nurse critically observed, this reliance on nurses as multifaceted problem-solvers does not extend to recognition of institutional leadership potential. She pointed out that Health Ministry positions of authority almost ubiquitously remain in the hands of male doctors, while nurses' work enhances the image of hospitals and Directors. Nurses' absence from administrative positions has been documented elsewhere in Latin America (Squires, 2007).

Nurses' intensified workload reinforces and interacts with a gendered burden of domestic responsibilities. In the participants' analysis, the cultural machismo behind this also contributes to marital instability for nurses. Many participants spoke of divorce and single motherhood as very common among Salvadoran nurses, a pattern also found in Mexico (Squires, 2007) and in my own research in Nicaragua. Heriberto, a male nurse, commented somewhat self-deprecatingly from his own experience that typically men cannot tolerate how their wives' work makes them absent from the home and less attentive to them. He admitted, in relation to his own divorce from a nurse, that he felt neglected by his busy wife. 'Because as a man one demands time ... we're very accustomed to the fact that besides having her kids, a woman has another large son, and that's us!'

Reduced Employment Prospects and Persistent Precarity

The field research was carried out while the FMLN government was in the midst of undoing some of the legacies of neoliberal health-care. One of these was the extensive reliance on flexible hiring. Nurses who were still working in temporary contracts or had only recently benefitted from conversion to full-time positions had fresh reflections on the negative impacts. Temporary contracts, of course, posed an economic strain and source of uncertainty for those starting their careers. Participants in short-term hospital positions also talked about constraints on voice in the workplace; anxiety about contract renewal affect one's willingness to resist or report bad conditions or behavior. It has been found elsewhere that temporary workers in general have less 'support from supervisors or other co-workers ... [and] ... can actively be resented, rather than supported, by more permanent workers' (Lewchuk et al., 2007: 116). In this respect, two young hospital nurses on contract spoke of aggression and bullying by more senior, permanent colleagues, both nurses and doctors. One was close to tears in recounting her experiences, and told of often praying as a way of maintaining self-esteem. Though the two nurses in this study who benefitted from conversion to full-time positions were generally relieved, one voiced disappointment that the salary increases to which they were now entitled were not retroactive over her nine years of employment in annual contracts.

It became clear in the focus groups, however, that precarity is a persistent problem for Salvadoran nurses, manifesting not only in the gradually diminishing presence of temporary contracts in the formal public sector, but also in nurses' increasing recourse to informal private sector work. This can be seen as a lingering impact of neoliberal cutbacks and reforms. In other developing country contexts, neoliberalism has generated increasing informal sector employment and entrepreneurship in health-care, a kind of 'passive privatization' (Muschell, 1995, cited in Segall, 2000). In a typical informal employment scenario in El Salvador, participants explained, the employer might recruit a nurse directly or through a third party contractor. The typical contractor, who might be a nurse, is hired by a family for something like US\$700/month. Since she cannot provide the service herself, she hires one or more nurses for US\$200/month and pockets the difference. A focus group participant who was working in this kind of contract summarized her experience:

The worst form is through the contractor; the kind that charges directly is better. The pay is very low, and on top of that, it is unstable. It can be once in a while, or for one day or for 12 hours, or for some months but it's still a much lower pay, without benefits except for the meals that they give us in the home.

This was a growing phenomenon, especially among newer nurses. A primary cause, participants signaled, was a surplus of nursing graduates in relation to available full-time positions, in turn owing to a steady growth in private nursing school admission numbers. Several of the participants

in the student focus group admitted their willingness to accept inferior positions. One nursing student stated:

I was saying to my friend, sort of in a joking way, that at this point, I would work a shift for \$10 or \$15 given the needs I have. Some people say, 'but how can you sell your labor and your knowledge that cheap?' But I respond that it's better than nothing. Five, ten, or fifteen dollars will help me with my breakfast.

A participant in a different focus group had graduated from the National University two years earlier and had been working exclusively in contracts of several months, including a two-month *ad honórem* position. She observed, 'Look, from my graduating class, the majority don't have work because there is no work in the hospitals. In other words, they need staff but they say that they don't have resources to pay staff.' This quotation captures a paradox seen in other developing countries, the quintessential case being the Philippines: namely, that there exists a large unmet need in the public system alongside rising unemployment.

These findings also lend credence to the widespread perception of labor wastage, whereby nurses are either unemployed or qualitatively under-employed, a problem throughout Latin America (Nigenda et al., 2006). Such a situation is bound to generate acceptance of inferior positions – contingent work with low pay and no benefits. It is also likely to make out-migration an attractive option for some, and there was indeed suggestion of this in the student focus group as well as in interviews with directors of two private nursing schools.

Informal sector precarity for nurses shows no sign of abating, notwithstanding the government's overall shift away from neoliberalism in health-care. The 'Constructing Hope' health reform itself has no means of addressing the behavior of the private sector training institutions. In 2013, El Salvador's nine nursing programs (of which only one is public) graduated 425 degree nurses, 214 *tecnólogos* (for a combined 639 graduates eligible for professional nurse positions) and 1531 *técnicos* (MINSAL, 2014).⁶ This reflects increases of 57%, 23%, and 54% respectively since 2010 (MINED, 2011), which supports participants' assertions that the numbers are steadily growing. These figures also mean that in one year, the schools are graduating the equivalent of 20% and 39% of MINSAL's existing nurse and *auxiliar* workforce. Private nursing schools are not only increasing admissions but sometimes also expanding the levels of training they offer, for example from the degree to non-degree programs or vice-versa, and opening entire new satellite campuses.

The broader backdrop to the problem is the restructuring of nurses' education in recent decades. In the 1990s, the ARENA government withdrew the state from its decades-long role in nursing education, creating a void that non-state institutions stepped in to fill. The first and largest of these, the Specialized Institute for Higher Education of Health Professionals of El Salvador (IEPROES), has an annual admission of between 500 and 600 students. In comparison, the average annual admission to the Bachelor of Science in Nursing program at the only public post-secondary institution, the National University, is about 60. Six other universities, all of them private, also offer the degree (WHO, 2013). The ARENA government also transferred the regulation of nursing education from MINSAL, which traditionally determined the number of admissions in the National Nursing School, to the Ministry of Education, which does not set limits on private sector schools.

It is ironic but not unprecedented that too many nurses are being graduated to fill existing positions, and yet short-staffing and inadequate nurse-patient ratios persist in the public sector; this is documented as a problem on an even greater scale in the Philippines (Masselink and Lee, 2013). The private schools have an interest in continuing to add admission spaces, and for complex reasons students still enroll. Statements by both senior nurses and the nursing students in this study suggest that they and their parents may be misinformed about the domestic job market at the outset of choosing nursing as a career, and that the private institutions are implicitly misleading them.

Several participants in the study placed a great deal of responsibility on these institutions for a lack of transparency about employment prospects. The Salvadoran case supports the assertion that where the state stays out of regulating nursing program admission numbers, overproduction can result (Brush and Sochalski, 2007; Masselink and Lee, 2013; Watson, 2010).

Remuneration

The adequacy of earnings, the most readily quantifiable measure of the value placed on care work, can be considered in both absolute and relative terms. When the study participants talked about the absolute sufficiency of their salary, the majority reported that a base monthly salary of US\$525 and US\$425, respectively, for professional nurses and *auxiliares* in the MINSAL system, leaves them struggling to provide for their families. The figures can be compared with the cost of living in El Salvador for the period in which most of the field research was carried out. The expanded market basket, considered the cut-off level for relative poverty (UNDP, 2010), adds clothing, shelter, health, and a few miscellaneous expenses to the basic market basket, which consists only of food expenses. Although there is no official income cut-off for the expanded basket in El Salvador, the UNDP pegs it at twice that of the basic market basket (UNDP, 2010: 192). The expanded basket for an average-sized household of 3.73 members in July 2012, therefore, was about US\$380 (Correo del Orinoco, 2012; UNDP, 2010). This means that while professional nurses could be considered to be doing alright, those employed as *auxiliares* have a starting salary that places them uncomfortably close to this de facto poverty line in the first five years of their employment.

The picture looks different again for other categories of nurses, such as those in public institutions governed by other ministries. In the Military Hospital, for example, there are occasional bonuses, but no salary grid increases until one has worked for 25 years. In the prison system, where the labor relation is with the Ministry of Security and Justice, professional nurses earn just US\$350/month, according to several participants. Also, with the phase out and conversion of temporary positions, salary increases and benefits that many nurses missed out on (sometimes for many years) are not retroactive. And then there is the income of the new graduates, who are being pushed into informal temporary work. Their earnings fall closer to, if not below, the expanded basket, while they must also pay for out-of-pocket health-care expenses for themselves and their dependents. These varied situations help to explain why many nurses feel compelled to hold more than one job. Even those with full-time positions in the MINSAL or ISSS system often take additional work in a private facility or in non-nursing activities. Furthermore, it is logical to assume that unemployment and underemployment, which the nurses' narratives suggest are increasing, will exert a downward pressure on all nurses' earnings in the future. El Salvador's 'Constructing Hope' health-care reform does not include plans to increase nurses' salaries (WHO, 2013).

Participants also talked about remuneration in relative terms. Though this theme overlaps with that of workload intensification, there are additional kinds of relative considerations. For example, several asserted that nurses assume a much higher risk of injury and illness in their work than do other health-care workers. One participant pointed out:

We are exposed to sleep deprivation which destabilizes mental health. We are exposed to lethal germs, to bacteria that can be transmitted to us if our defenses are lowered. Now with all of the illnesses that are transmitted via a needlestick injury, and these are illnesses with no cure. ... So I think the pay we receive is not equitable for all the responsibilities and the risks.

It also became clear that nurses working in the primary sector, which entails travel over sometimes difficult terrain in the zone of their clinics, face additional hazards. These include travelling in the

back of over-packed pick-up trucks, dog attacks, and having to negotiate with *maras* – the notorious youth gangs – for permission to enter communities.

Conclusion

The nurses' narratives make clear that austerity policies in health-care were a source of increased physical and mental strain, economic insecurity and uncertainty, and demoralization. In expanding the health-care system in benefit of long underserved groups, the FMLN's 'Constructing Hope' reform, which has earned praise from the WHO (2013) for its achievements in key health indicators, could well prove to be one of the most remarkable transformations of its kind in Latin America. Policies since 2009 also promise several improvements to nurses' working conditions and opportunities. Hundreds of full-time positions have been added to the MINSAL system, mostly in the primary sector. The phasing out of temporary contracts across MINSAL, including the unpaid *ad honórem* positions, signals a much more progressive understanding of labor justice for health-care workers than under ARENA. There is also a commitment to ensuring that nurses with degrees no longer labor in the pay-grade of *auxiliares*.

But there are at least three realms in which neoliberalism and devalued care work have left a lasting legacy. For one, because of persistent short-staffing, there has been no relief from workload intensification in clinics and hospitals. Secondly, precarious employment persists in the informal private sector, with little sign of abating. Third is the stagnation of earnings in absolute and relative terms for many nurses. The findings suggest that gendered assumptions persist among current health-care authorities, whereby nurses' work capacities are presumed to be infinitely elastic. A related assumption is that nurses will uncomplainingly absorb incremental increases to their duties. While it is fairly clear how ARENA health-care planners counted on 'the role of normative femininity' (Selberg, 2013: 23) in making nurses willing to 'cover for' (Selberg, 2013: 9) the ill-equipped and short-staffed organizations in which they worked, the FMLN government seems to have not completely broken with this pattern. Nurses in a sense continue to cover for unreplenished human resources in existing institutions.

Another source of the problem may simply be the depth with which the FMLN government is willing or able to enact its principled rejection of neoliberalism in health and other areas. It has been noted that neoliberal policies in Latin America have staying power beyond the crises that they were launched to solve (Goodale and Postero, 2013). Several scholars have observed that while the region's new left governments are united in the view that prior regimes took austerity too far, especially when it comes to basic services (Clark, 2015), most have refrained from radical redistributive reform that would affect economically powerful groups (Sankey, 2016). In El Salvador, this is well exemplified in the *laissez faire* approach to the private post-secondary schools that train nurses and *auxiliares*. While these enterprises proliferated in the ARENA years, a lack of regulation persists today over the scale of their activities.

One limitation of the study is that unemployed and under-employed nurses were not specifically recruited. Nevertheless, the participants' narratives indicated that labor wastage is a growing dilemma largely rooted in the training system. More quantitative and qualitative data on this could equip advocates in the profession to press for new approaches. Similarly, systematic study is needed into the numbers of nurses who emigrate, the most common destinations, how they fare, and how 'social and political events' at home factor into their decision-making (Squires and Beltrán Sánchez, 2013: 41). In this regard, it would be useful to understand how Salvadoran nurses are affected by, and how they cope with, the dismaying escalation of violence stemming from the *maras* and organized crime. If care work is to be more highly valued in the future, it should not be

taken for granted that nurses can take on the additional challenges this presents without additional resources and support.

Acknowledgements

The author is grateful to the anonymous reviewers and to Neil McLaughlin for helpful comments on an earlier draft, and to Sara González and Irma Molina for their research assistance.

Funding

The research was funded by the Social Sciences and Humanities Research Council of Canada (Grant no. 410-2009-2093).

Notes

1. This study is focused on professional nurses, not *auxiliares*, a term that translates roughly as nurses' aides or nursing assistants. In much of Latin America this position requires two to six months of training. In El Salvador, after nurse training was revamped in the mid-1990s, it has required completion of a two-year *técnico de enfermería* program, contrasting with the five-year Bachelor's degree and the four-year *tecnólogo* diploma. That said, as elsewhere in Latin America, nurses with degrees or technical diplomas are often sub-employed in the *auxiliar* job title.
2. An exception to this general global sequencing was Chile, where Pinochet's authoritarian government began to dismantle and reorganize social programs in the early 1970s.
3. See: <http://www.datosmacro.com/estado/gasto/salud/el-salvador>
4. The ISSS employs 1137 nurses (MINSAL, 2014).
5. Personal correspondence with key informant, August 2015.
6. Graduates with the degree or the *tecnólogo* diploma can be hired as professional nurses; those trained as *técnicos* may only work as *auxiliares*.

References

- Abramovitz M and Zelnick J (2010) Double jeopardy: The impact of neoliberalism on care workers in the United States and South Africa. *International Journal of Health Services* 40(1): 97–117.
- Almeida P (2008) The sequencing of success: Organizing templates and neoliberal policy outcomes. *Mobilization* 13(2): 165–87.
- Arditi B (2010) Arguments about the left: A post-liberal politics? In: Cameron MA and Hershberg E (eds) *Latin America's Left Turns: Politics, Policies, and Trajectories of Change*. Boulder, CO: Lynne Rienner, 145–167.
- Arévalo Flores GG, Ayala Salinas de Reyes RM, Aníbal Barrera H, et al. (2009) *Ausentismo imprevisto del personal del departamento de enfermería en el Hospital Nacional de Maternidad, en el período de enero a julio 2009*. San Salvador.
- Ashley J (1976) *Hospitals, Paternalism and the Role of the Nurse*. New York, NY: Teachers College Press.
- Beasley-Murray J, Cameron MA and Hirschberg E (2010) Latin America's left turns: A tour d'horizon In: Cameron MA and Hershberg E (eds) *Latin America's Left Turns: Politics, Policies, and Trajectories of Change*. Boulder, CO: Lynne Rienner, 1–20.
- Bigo V (2010) The care paradox: Devaluing and idealising care, the mother, and mother nature. *International Journal of Green Economics* 4(2): 117–133.
- Boris E and Klein J (2012) *Caring for America: Home Health Workers in the Shadow of the Welfare State*. New York, NY: Oxford University Press.
- Brush BL and Sochalski J (2007) International nurse migration: Lessons from the Philippines. *Policy, Politics and Nursing Practice* 8(1): 37–46.
- Budig MJ and Misra J (2010) How care-work employment shapes earnings in cross-national perspective. *International Labour Review* 149(4): 441–460.

- Cáceres Y (2010) 675 plazas de auxiliares son ocupadas por enfermeras. *El Salvador.com*, 17 October. Available (consulted 16 September 2016) at: http://archivo.elsalvador.com/mwedh/nota/nota_completa.asp?idCat=6364&idArt=5237286
- Clark MA (2015) The new left and health-care reform in El Salvador. *Latin American Politics and Society* 57(4): 97–118.
- Correo del Orinoco (2012) Bajan inflación y costo de canasta básica en El Salvador. *Correo del Orinoco*, 12 September. Available (consulted 16 September 2016) at: <http://www.correodelorinoco.gob.ve/investigacion/bajan-inflacion-y-costo-canasta-basica-salvador/>
- England P, Budig M and Folbre N (2002) Wages of virtue: The relative pay of care work. *Social Problems* 49(4): 455–473.
- Galdámez E (2001) 4000 piden retiro voluntario. *Diario de Hoy*, 6 October. Available (consulted 16 September 2016) at: <http://www.elsalvador.com/noticias/2001/10/6/NEGOCIOS/negoc8.html>
- Goodale M and Postero N (2013) Revolution and retrenchment: Illuminating the present in Latin America. In: Goodale M and Postero P (eds) *Neoliberalism, Interrupted: Social Change and Contested Governance in Contemporary Latin America*. Stanford, CA: Stanford University Press: pp. 1–22.
- Government of El Salvador (GOES) (2014) *Plan Quinquenal de Desarrollo 2014–2019*. El Salvador: Secretaría Técnica y de Planificación. Available (consulted 16 September 2016) at: <http://www.presidencia.gob.sv/wp-content/uploads/2015/01/Plan-Quinquenal-de-Desarrollo.pdf>
- Guevara EP and Mendias E (2002) A comparative analysis of the changes in nursing practice related to health sector reform in five countries of the Americas. *Pan-American Journal of Public Health* 12(5): 347–253.
- Heitlinger A (2003) The paradoxical impact of healthcare restructuring in Canada on nursing as a profession. *International Journal of Health Services* 33(1): 37–54.
- Hochschild A (2009) Love and gold. *S&F Online* 8(1): 1–6. Available (consulted 16 September 2016) at: http://sfonline.barnard.edu/work/hochschild_01.htm
- Homedes N, Paz-Narváes AC, Selva-Sutter E, et al. (2000) Health reform: Theory and practice in El Salvador. In: Lloyd-Sherlock P (ed.) *Healthcare Reform and Poverty in Latin America*. London: University of London Institute of Latin American Studies, 57–77.
- Homedes N and Ugalde A (2005) Human resources: The Cinderella of health sector reform in Latin America. *Human Resources for Health* 3(1): 1–12.
- Huezo R (2002) Actualizan planillas: 2,500 plazas menos. *El Diario de Hoy*. Available (consulted 16 September 2016) at: <http://www.elsalvador.com/noticias/2002/10/1/negocios/negoc1.html>
- Laurell AC (1991) Crisis, neoliberal health policy, and political processes in Mexico. *International Journal of Health Services* 21(3): 457–70.
- Lewchuk W, De Wolff A and King A (2007) Employment strain, precarious employment, and temporary employment agencies. In: Shalla V and Clement W (eds) *Work in Tumultuous Times: Critical Perspectives*. Montreal: McGill Queens University Press, 98–130.
- Lund F (2008) Paid care providers: Nurses, domestic workers, and home-based care workers. *The Political and Social Economy of Care Project*. UNRISD Research Report 4, South Africa.
- Mackintosh M and Tibandebage P (2006) Gender and health sector reform: Analytical perspectives on African experience. In: Razavi S and S Hassim S (eds) *Gender and Social Policy in a Global Context: Uncovering the Gendered Structure of 'the Social'*. Basingstoke: Palgrave Macmillan/UNRISD.
- Masselink LE and Shoou-Yih DL (2013) Government officials' representation of nurses and migration in the Philippines. *Health Policy and Planning* 28: 90–99.
- Ministerio de Educación (2011) *Resultados de la Información de Instituciones de Educación Superior 2011*. (MINED 2011). El Salvador. Available (consulted 16 September 2016) at: <https://www.mined.gob.sv/jdownloads/Informacion%20Estadistica%20de%20Educacion%20Superior/Libro%20Estadistica%20IES%20Final%20Nov.pdf>
- Ministerio de Salud (2014) *Informe de Labores 2013–2014*. (MINSAL 2014). El Salvador. Available (consulted 16 September 2016) at: <https://www.salud.gob.sv/servicios/descargas/documentos/Documentación-Institucional/Memorias-de-Labores/Memoria-de-Labores-2013–2014/>

- Ministerio de Salud (2015) *Informe de Labores 2014–2015*. (MINSAL 2015). El Salvador. Available (consulted 16 September 2016) at: <https://www.salud.gob.sv/servicios/descargas/documentos/Documentación-Institucional/Memorias-de-Labores/Memoria-de-Labores-2014–2015/>
- Muntaner C, Salazar RM, Rueda S and Armada F (2006) Challenging the neoliberal trend: The Venezuelan health care reform alternative. *Canadian Journal of Public Health* 97(6): 119–24.
- Nigenda G, Ruiz JA, Rosales Y and Bejarano R (2006) University-trained nurses in Mexico: An assessment of educational attrition and labor wastage. *Salud Pública de México* 48(1): 22–9.
- Pan-American Health Organization (2011) *Regulación de Enfermería en América Latina*. (PAHO Area de Fortalecimiento de Sistemas de Salud. Unidad de Recursos Humanos para la Salud 2011). Washington, DC: World Health Organization, Health Human Resources Series No. 56.
- Reverby S (1987) A caring dilemma: Womanhood and nursing in historical perspective. *Nursing Research* 36(1): 5–11.
- Reverby S (2002). A legitimate relationship: Nursing, hospitals, and science in the twentieth century. In: Baer ED, D'Antonio P, Rinker S and Lynaugh JE (eds) *Enduring Issues in American Nursing*. New York, NY: Springer, 262–281.
- Romero Ballén MM (2012) Calidad de vida de las(os) enfermeras(os) bajo las políticas neoliberales y su impacto en el cuidado de la salud. Paper presented at the 30th Annual Congress of the Latin American Studies Association, 22 May, San Francisco, CA.
- Sankey K (2016) What happened to the pink tide? *Jacobin*. Available (consulted 16 September 2016) at: <https://www.jacobinmag.com/2016/07/pink-tide-latin-america-chavez-morales-capitalism-socialism/>
- Segall M (2000) From cooperation to competition in national health systems – and back? Impact on professional ethics and quality of care. *International Journal of Health Planning and Management* 15: 61–79.
- Selberg R (2013) Nursing in times of neoliberal change: An ethnographic study of nurses' experiences of work intensification. *Nordic Journal of Working Life Studies* 3(2): 9–35.
- Squires AP (2007). *A Case Study of the Professionalization of Mexican Nursing: 1980 to 2005*. Unpublished doctoral thesis, Yale University.
- Squires A and Beltrán Sánchez H (2013) Strengthening health systems in North and Central America: What role for migration? Washington, DC: Migration Policy Institute. Available (consulted 16 September 2016) at: <http://www.migrationpolicy.org/pubs/RMSG-HealthCare.pdf>
- Squires A and Juárez A (2012) A qualitative study of the work environments of Mexican nurses. *International Journal of Nursing Studies* 49: 793–802.
- Trochim WMK (2008) Nonprobability sampling: Research methods knowledge base. Available (consulted 16 September 2016) at: <http://www.sfu.ca/~palys/Purposive%20sampling.pdf>
- Ugalde A and Homedes N (2005) Neoliberal health sector reforms in Latin America: Unprepared managers and unhappy workers. *Pan American Journal of Public Health* 17(3): 202–9.
- United Nations Development Program (2010) *Informe sobre Desarrollo Humano (INDH) El Salvador*. (UNDP 2010). El Salvador.
- Watson R (2010) The nursing workforce: Achieving homeostatis. *Contemporary Nurse* 36(1–2): 45–48.
- World Health Organization (2013) Mid-level health workers for delivery of essential health services: A global systematic review and country experiences. *Country Case Studies: El Salvador*. Available (consulted 7 October 2016) at: WHO/hss/hwa/mlp 2013/ENG