International Journal of Public Health (2020) 65:1011–1017
https://doi.org/10.1007/s00038-020-01420-4

ORIGINAL ARTICLE

Medical labour under neoliberalism: an ethnographic study in Colombia

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Received: 30 January 2020 / Revised: 11 June 2020 / Accepted: 22 June 2020 / Published online: 25 August 2020

Abstract

Objectives In order to increase the knowledge about the impacts of neoliberal market forces on physician's labour, this article's objectives are to analyse how and why the labour of physicians is transformed by neoliberalism, and the implications of these transformations for patient care.

Methods Ethnographic investigation is carried out through semi-structured interviews with 20 general practitioners at public and private facilities in Colombia. The interviews were contrasted with national studies of physician's labour since the 1960s. A "mock" job search was also simulated. The analysis was guided by Marxian frameworks. The study was approved by a Human Research Ethics Committee, and informed consent was obtained from all participants.

Results The overpowering for-profit administration of the Colombian healthcare system imposes productivity mechanisms on physicians as a result of a deregulated labour market characterized by low salaries, reduced and self-funded social security benefits, and job insecurity. Overworked physicians with reduced autonomy become frustrated for not being able to provide the care their patients need according to clinical standards.

Conclusions Under neoliberal conditions, medical labour becomes exploitable and directly productive through its formal and real subsumption to Capital. The negative consequences of a progressive loss in physician's autonomy unveil the incompatibility between neoliberal health systems and people's health.

Keywords Employment · Clinical medicine · Physician–patient relations · Quality of health care · Neoliberalism · Exploitation

Introduction

The organization, financing, and delivery of health services in Colombia have been drastically transformed since the 1990s with the consolidation of a market-based or neoliberal healthcare reform. This reform, based on the "structured pluralism" model (Londoño and Frenk 1997), proposes that a mix of public and private insurance companies and healthcare institutions enter into competition in a "regulated market." Regulation, however, has been one of the reform's significant challenges (Bauhoff et al. 2018; Prada and Chaves 2019). The population was divided into two regimes: those who could purchase insurance (i.e. contributory regime) and those who needed governmental subsidies to enter into the insurance market (i.e. subsidiary regime.) Given its funding mechanisms and the increase in the number of people with insurance, this reform has been used as a model to expand a privatizing version of Universal Health Coverage around the world (Abadía-Barrero and Bugbee 2019). While many problems in terms of quality of care, inequalities, corruption, and the dismantling of public healthcare networks have been reported in Colombia (Tajer 2003), less is known about the transformations of labour conditions of the healthcare workforce.

The economic and political theory of neoliberalism entered the global south early in the 1970s via dictatorship. Later on, this doctrine was imposed via technical assistance

This article is part of the special issue "Market-driven forces and Public Health".

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and loans subjected to compliance with structural adjustment policies (Harvey 2007). The required adjustments included austerity in social investment which, among others, led to policy reforms in health, labour, and education. (In Colombia, Laws 100 of 1993, 50 of 1990 and 30 of 1990, respectively.) As unions and other social organizations got dismantled, solidarity ties were replaced by the logic of entrepreneurship, "free markets", and personal responsibility. To compensate for the excessive rewards of those better suited to outcompete others in the market, social protection was transformed via the "social risk management" paradigm in which those unable to enter the market were identified and enrolled into subsidies-based programmes (Giraldo 2007).

Law 100 of 1993 in Colombia was structured around insurance companies taking over the administration of the healthcare system. Rather than receiving direct payments by the state, hospitals were pushed to compete for contracts with the insurers. In this process, both private clinics and "public" hospitals transformed their institutional culture to profitable and self-sustaining enterprises (García 2007), in which a flexible labour force with precarious working conditions augmented their chances to assure profits in the new "regulated market" scenario. Healthcare workers and institutions were forced to become self-entrepreneurs, commodify daily processes, and compete within the market of insurance companies and service providing institutions. Hence, the Colombian neoliberal response in health prioritized the financial logics of insurance companies and accommodated public health and clinical medicine to their needs. The state was supposed to correct market imperfections through surveillance and control, but proved to be inefficient and/or unwilling. Indeed, the business of health became extremely lucrative to insurers given vertical integration and the constant flow of public and workers' money to cover the cost of the premium and uncovered care. At the same time, massive corruption and misuse of the system's resources expanded, and the state agencies took more than a decade to detect them (Webster 2012). Nonetheless, the enormous political and economic power of the insurance sector became very difficult to control.

This neoliberal colonization of the health field led us to question the kinds of transformations that medical labour had undergone. Discussions about physician's labour as part of the history of the capitalist system, however, do exist. Historical studies informed by critical political economy indicate that in Latin America (LA) physician's labour was unproductive or only indirectly productive in several ways: (1) it aided in recuperating or maintaining the productivity of the workforce; (2) it maintained the reserve workforce through preventive actions and maternal child health; (3) it contributed to collective labour by supporting personnel selection processes; (4) physicians' income allowed them high levels of consumption; (5) through their work, they assured the circulation of money; and (6) mediated the consumption of commodities (i.e. biotechnologies, pharmaceuticals, laboratory tests, and so on.) (Arouca 2008). Since the 1970s, however, the progressive growth of the medical industrial complex and insurance sectors in health demand further studies about the relationship between physicians and the capitalists of the health sector (Iriart et al. 2011; Launer 2015). Given the limited knowledge about the impacts of neoliberal market forces in physician's labour, this article's objectives are to analyse how and why the labour of general practitioners (GPs) is transformed by neoliberalism, and the implications of these transformations for patient care.

Methods

Data collection for this ethnographic investigation occurred during 2013 and 2014, in Colombia, and included in-depth semi-structured interviews with 20 general practitioners, field notes that aimed to describe reflections and emotions related to the interviews and the work places, and a "mock" job search through the internet. In terms of subjectivity and reflexivity, key domains of ethnographic research (Guber 2011), all data were collected by the first author, a MD/MPH/PhD candidate who was not working in clinical medicine at the time. Hence, the rapport and the interactions during the interviews were characterized by her dual role: a colleague capable of understanding the specifics of medical practice, and an outsider who wanted to know about the current labour market.

The interviewees, twelve male and eight female, had between 1 and 28 years of medical experience and worked in outpatient clinics and emergency departments at both public and private facilities in Bogotá, Cali, and Cartagena. Our sampling approach combined convenient and snowball techniques (Patton 2002). For recruitment, we visited a handful of health facilities. The first author approached physicians who were working during their shifts, told them about the study, asked if they would be interested in participating, and scheduled a follow-up time for a more extensive explanation of the study and the interview. These first participants and other colleagues who knew about the study referred to us other participants who were approached via telephone. Only one physician refused to participate in the study.

The interview guide was piloted in the first interview. Given that no major changes were made to the guide, this first interview was included as part of the sample. The guide was structured around two main themes: labour conditions and physician–patient relations during medical encounters.

Each participant chose the place and time of the interview; most of them preferred their medical office or a nearby cafeteria. They agreed to meet before, during, or after their shift. Only the participants and the interviewer were present during the conversation. Each interview lasted between 40 and 150 min. One of the participants was interviewed twice for a total of 240 min of interview time since he changed his job and wanted to share his new job experience. No other interviews were repeated, and most participants were not contacted again after the interviews. All interviews were recorded and transcribed verbatim.

Data analysis was conducted throughout the process by both authors and was based on ethnographic reflexivity (Guber 2011) and a constant iteration process (Agar 2006), between Marxian frameworks around labour and health (Morales and Eslava 2015; Navarro 1976; Waitzkin 2018) and empirical data. Besides the triangulation of researchers' perspectives, preliminary analyses were presented to expert audiences in both ethnographic methods and critical analysis of the healthcare system to reduce threats to validity (Maxwell 1996). Preliminary ideas and analyses were also shared with some interviewees during the interviews to aid in the reflexivity process and validity. Data collection stopped once saturation was reached.

In order to place the interviews historically and respond to our aims, we contrasted our data with national studies of the market of medical labour since the 1960s**.** The "mock" job search was used to assess the contractual conditions offered throughout the nation, and we joined some medical groups on Facebook to contrast our data with the discussions that physicians were having around their labour conditions. The study was approved by a Human Research Ethics Committee, and informed consent was obtained from each participant included in the study.

Given that salaries from 1964 to the present were compared, each Colombian pesos (COP) value was first converted to the Colombian legal minimum wage of the respective year and then to Euros (€), according to 31 December 2019 rates (1 COP = € 3681). When necessary, the values were adjusted to 2019 according to the Colombian average inflation.

Results

Precarization and proletarianization of physician's labour

When talking about labour conditions, Dr. P, a GP with more than 20 years of clinical experience, said that labour conditions before the 1990s were better from an economic and professional point of view, both in terms of job stability and social prestige. He compared his current working conditions with those of a close relative of his, who worked as a GP during the 80 s, also at a public hospital: "his salary was 20 times the national minimum wage of his time. It was a good salary, he lived well, without worries, did not have to kill himself working in 5 places trying to have a decent income. Today's salary for an 8-h job is on average 5 to 6 minimum wages. In addition, today most doctors do not have stable jobs, work per hours, per days, [in shifts that are paid at the same hourly rate, whether they are] from 7 to 1, from 1 to 7, or nights, Saturdays, Sundays".

During the interview, Dr. P reiterated that job stability and prestige have changed drastically in Colombia and that physicians' current labour market is dictated by a "price" that is unilaterally set up by the employers though temporal contracts with much reduced and self-funded social security benefits. This is the main characteristic of neoliberal/flexible labour reforms in which salaries with benefits and union protection were replaced by a "free" labour market (Ahumada 1996; Harvey 2007) which opened the road to the precarization and proletarianization of physician's labour that Dr. P spoke about.

Those drastic changes were visible even in the first years after the reform. According to a 1998 national census, between 1994 and 1997, the percentage of healthcare workers with full-time formal contracts grew by 10%, whereas the recruitment of workers with temporary and deregulated contracts increased by 312% (Ministry of Health 1998). Temporary, flexible, and precarious contracts became the norm during the next decades (Brito 2000). By 2019, only 42% of GPs who answered a survey had formal contracts (Colombian Medical College 2019).

Work-related harassment and job insecurity

At the time of our interviews, the neoliberal labour (Law 50/1990) and health system reforms (Law 100/1993) were well established and a general shift towards productivity was evident. Indeed, the word "productivity" was insistently mentioned in the interviews. Interviewees spoke about a range of productivity strategies "suggested" by the directors and managers of health facilities. According to Dr. M, the institutions wanted to make them "rendir" (i.e. get the most of them given what they get paid.) "To justify your salary you must attend 18 patients in a [6-h] day, not formulate more than 85%, have less than 10% of referrals to specialists and less than 32% of clinical laboratory tests a month. If you exceed those caps, you are a doctor that is not cost-effective for the institution". These percentages are just one example and vary depending on the institution. In other cases, the auditing culture in medicine (Mulligan 2016) was represented in money caps, for example not to exceed € 340 in diagnostic images per month.

Informal advice, subtle emails, commitment letters, wake-up calls, and invitations to productivity meetings with prizes for doctors according to their performance were described as "feedback" strategies. Medical coordinators advise the GP to "cut [expenses] down" and adjust to gaps. Dr. R was told ""you have to delay things more", that was the word, "delay", but why delay if a patient needs it? (…) It's like going against everything we've been taught and ethics". Dr. M saw "sly workmates, and they aren't sly just because they want to but because they have to. For example, if a patient has an obvious dermatologic lesion, what does one have to do? I'll send her Betamethasone or something, I see her two more times, and then I can refer her. What's all that for? So that the record states that you gave it a try, that you tried to do something but the patient did not respond".

According to our interviewees, physicians have "good solving skills" when they "manage patients/get rid of without offering tests or treatments". But the physicians interviewed argued that such a desired combination of "solving skills" and little expenses distorts the idea of good and bad medical practice. Dr. P explained: "With that idea of the good doctor or the bad doctor, it's like a double standard because you're a good doctor if you don't send anything, you don't spend anything, and the patient gets ping-ponged. Good doctor for them but bad doctor for the patient, why can't I ask for the tests the patient needs to get her out of the problem? No, because they fire me".

We found another expression of the same phenomenon through the experience of an emergency room (ER) physician, which helped us to identify some of the deep and structural effects of the financial transformation of the healthcare system.

At the ER where Dr. K worked, some months ago a new medical coordinator brought the productivity trend and started to control the number of patients that every doctor should see per hour. Dr. K said: "I actually think that it does not benefit the patient because if we talk about productivity then we have to see a number of patients per hour so, for example, when there are 80-year-old grannies everyone skips them, nobody calls them, why? Because that person is going to accrue more time, then I won't be able to see the 12 or 14 or 20 patients I have to see and my number [quota of patients per shift] will decrease. If a patient arrives and we know that it is more complicated, a renal colic, chest pain or cancer patients, something that one has to comment on with the specialist, then my colleagues start to skip them… 'cause the consultation time is much worse than in a headache, a flu, a diarrhea. So, the patient gets screwed over. If you must look at numbers, then it's no longer a quality [issue], it's quantity… then everyone runs, everyone".

Besides being skipped, the quality of care that patients received is further compromised by the disincentive to work in collaboration with specialists given that not only GP but all health workers are being held to the same productivity standard and need to rush.

Exploitation and subsumption

Other administrative technologies of managerial medicine (Mulligan 2016) shape the speed of the clinical encounter. Legally, in Colombia, a medical consultation should not last less than 20 min. However, Dr. M. discovered the hard way how salary and productivity are manipulated to increase rates of exploitation. He changed jobs with the expectation that he was going to earn more money. When he arrived to his first day of work, he discovered that he had 17 min per patient and had to work two more hours on Saturdays compared to his previous job. As the interview progressed and the reflexivity process sank in, he concluded that in fact, he was going to receive less "payment" per patient in his new job. Dr. M.'s reflections helped us understand the profit margin that managers of hospitals assure by shortening each medical encounter by 3 min, which we can now conceptualize as a relationship between surplus value of medical labour and rate of exploitation.

As shown in Table 1, given a monthly wage of 6 minimum legal Colombian salaries (€ 1430) for a 140 h per month (6 h-day included two Saturdays), if each medical consultation is billed for € 9.53 ($35,100 COP on 2020, according to a national tariff manual frequently used in billing), reducing the time per patient not only increases the total number of patients and therefore the exploitation rate, but also every minute of the medical encounter that is reduced generates a surplus higher than the previous minute. (Under these conditions, doctors produce their salary in the third part of the time they actually work.) These exploitation dynamics that were previously circumscribed to industry, signal, perhaps, the biggest transition of medicine in which the "unit of production" becomes materialized as time units per consultation.

While timing consultations has always been part of healthcare administration, what comes across as a powerful strategy of neoliberalism is the proletarization of physician's labour given the growing reserved army of physicians and their loss of unionized power to negotiate salaries, social security, or working conditions. Furthermore, under this privatized context, increased surplus out of each minute energizes capitalist accumulation patterns of insurance sectors rather than being socially distributed. As Dr. P explained, the impacts on quality of care are disregarded. During the orientation meeting for Dr. M's new job, after being told about the 17 min per patient standard, one of his colleagues asked "In 17 min of

Table 1 Simulation of costs, payments, and surplus according to the frequency of medical consultations. Colombia. 2020

Time per consultation (minutes)	Total consultations per month	What the doctor gets paid per consultation (€)	Surplus per consultation (€)	Monthly surplus (€)
20	420	3.81	6.90	2898
19	442	3.62	7.09	3135
18	467	3.43	7.28	3398
17	494	3.24	7.47	3692

Given a € 1430 salary for working 140 h-month and € 9.53 cost per consultation

consultation who's going to finish [on time]?" The answer they received was: "doctors, you have to generate strategies, for example, while doing the physical exam you can do counseling." But they interjected, "either I do the physical exam or I give counseling because how am I going to ask and talk if I have the stethoscope in my ears?".

Low salaries = multiple jobs

Our interviewees made clear that given the low salaries multi-employment has become a way to maintain a bourgeoisie standard of living. However, in our job simulation, we identified that a 6 h-day work is usually assumed as "half time", even though this exceeds what is legally mandated. In Dr. K's workplace, out of 45 emergency physicians, 10 worked "part-time" (90 to 140 h a month) and many were doing another "half-time" elsewhere, then "everyone is late because if you leave [your other job] at 1:00 you will not be able to get here at 1:00".

These doctors can't either have lunch, they run from here to there, they don't rest. Dr. M said: "I know colleagues who come to work at 6:30 in the morning, work a shift until 1:00 or 12:30 and start the other shift until 6 or 7 pm, can you imagine a person who works at that pace, after having seen 35 or 40 patients? In the last 2 h [of your second shift], do you have a head after seeing a computer screen all day…? And it's not like they get a coffee break or to go to the bathroom (…)".

According to Dr. M is not simply the toll that the exhaustion creates in them physically, it is also how excessive workload disincentivizes a thorough consultation and makes them prone to medical errors. He continues: "A person who has been working 8, 10 h, seeing patients every 17 min completely saturated with so much information can add an extra zero [in a prescription](…) you go at a pace that if you delay 2 min on a patient then you get behind, and you get behind, and you're super behind and the next patient is banging on the door and he's "why don't you take care of me fast?…" and the whole drama begins".

In this scenario, GPs acknowledge that they have to concentrate on the "chief complaint" and frequently neglect all the components of a full medical visit, including other complaints, the review of systems or a complete general exam, all of which is fundamental in disease prevention and early detection. Drs. K and M accounts reflect how the efforts that physicians make to keep multiple jobs and secure enough income come at a price. Indeed, reports of suicides, stress, and mental health problems among physicians were common during our fieldwork.

Discussion

Our results unveil how neoliberalism, through flexibilization reforms and a managerial approach to health care (Mulligan 2016), made medical labour directly productive and exploitable through what Marx called formal and real subsumption to Capital (Marx 1887). Formal subsumption, in our case, is visible through the extension of the workday, the higher rates of exploitation via lower salaries or less time per patient, and the need to work multiple jobs to make up for physician's historical loss of income. Real subsumption means that medicine loses its character as a liberal profession, primarily in its autonomy, and is pushed to adjust therapeutic protocols according to productivity-based restrictions. As a result, the role of GPs is transformed from being a gateway to the system to becoming one of its main access barriers.

Previous studies, both in Colombia and elsewhere, have indicated that market-based healthcare reforms brought about new bureaucratic practices and infrastructures that limit patient's access to care, increase inequalities, and further the profits of insurance companies (Abadía and Oviedo 2009; Mulligan and Castañeda 2018). Furthermore, it has been shown that the neoliberal legal structure of the system influences how judges use monetary logics to define the extent of the right to health care in Colombia (Abadia-Barrero 2016). Our results add to this literature by illustrating that the neoliberal legislation in health and labour, along with the healthcare system's financial sustainability and productivity demands (Mulligan 2010), trump semiological analysis, algorithms, or clinical guidelines. This can

result in clinical itineraries, meaning that under the current conditions, physicians' labour can add time and worries to the patient's experience and delay opportune diagnosis or treatment. As a result, patients seem to be trapped between substandard clinical encounters, heightened bureaucratic infrastructures, and neoliberal justice.

This approach to delaying treatment coincides with reports about the Colombian health system as one of the most important access barriers to timely health care, including some studies that have identified delays between time of diagnosis and effective treatment (de Vries et al. 2018; Manrique et al. 2017; Martínez and Iriarte 2019; Sánchez-Vanegas et al. 2013; Sanz 2017, 2020). It also coincides with the incredible amount of legal suits from patients trying to get their treatments approved by insurance companies, over 100,000 per year, which has been denounced as a neoliberal strategy that insurance companies use to increase profits (Abadía and Oviedo 2009).

In the field of physicians' labour, our data suggest that the commodification of health care and its resultant physicians' alienation contribute to medical errors, burnout, quitting jobs, and suicide, among others (Gordon and Winch 2018), which are on the rise. Our findings support these analyses. Nonetheless, we add to the literature in neoliberalism and health by unveiling the exploitation, proletarianization, and subsumption dynamics that underlie physicians' labour, which also explain why the neoliberal phase of capitalism and people's health are incompatible (Abadía-Barrero and Ardila-Sierra 2018; Martínez-Parra et al. 2018; McKee and Stuckler 2012; Mendes 2015; Stan and Toma 2019).

Limitations

While it is not possible to establish how much of the delays between diagnosis and effective treatment are the result of alienated, exploited, proletarianized, and subsumed physician's labour, we argue that these dynamics are constitutive of physician labour during neoliberalism. While the lack of data from other countries around physician's labour conditions impedes contrasts across countries, our research supports the claim that the incorporation of neoliberal ideology in health care configures corporative, productivity, and for-profit logics that legitimate "almost anti-medicine" (Anderson 2018) and anti-quality practices (Gordon and Winch 2018).

Acknowledgements This research was funded by the Colombian Administrative Department of Science, Technology and Innovation-Departamento Administrativo de Ciencia, Tecnología e Innovación (Colciencias) (Call 511-2010).

Conflict of interest The authors have no conflicts of interest to disclose.

Ethical approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee of ethics of the Faculty of Medicine of the National University of Colombia (Record number: 17-2011), and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent Informed consent was obtained from each individual participant included in the study.

Human and animal rights The research involves human participants.

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