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Time and the social reproduction of American health care

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SYNOPSIS

In this article, I argue that the restructuring of shift work in nursing is an important tool in the neoliberalization of health care in the US. Since the 1990s, nurses in the majority of hospitals in the US have switched from eight to twelve-hour shifts. This change, while popular among nurses, has had significant implications on the job itself. Questioning why a longer working day seems to be a victory for nurses, I argue that this change in shift work – this lengthening of the working day – is an important tool of neoliberalism that works to distract from issues of workload, overtime, resources, and staffing.

Introduction

While the United States has never had a comprehensive national health care system, neoliberal policies have intensified the privatization of health care and erode the small pockets of national care provisions. These policies have worked to restructure health care into the predominantly private service provision system that it is today (McGregor, 2001; Quadagno, 2005; Stoesz & Karger, 1991). Since the 1970s, private sector stakeholders increased their efforts to block any growth in the bud of a welfare state that Medicare created, and as the twentieth century ended, private health care services and insurers came to fully dominate the industry. Policy makers and private sector stakeholders did not limit their attacks to Medicare. They also implemented policies that restructured the work of health care. Nurses – the arguable backbone of health care – have watched their jobs change dramatically over the past 40 years. Patients are more acute, staffing is more limited, the distribution of resources is increasingly uneven, and paperwork and bureaucracy have grown immensely (Abramovitz & Zelnick, 2010; Lipscomb, Trinkoff, Brady, & Geiger-Brown, 2004). Time has also changed. Since the 1990s, health care facilities have moved away from the 8-hour shift, in favor of staffing nurses in 12-hour shifts. I argue that time and the restructuring of shift work in nursing is an important tool of this neoliberal reform, and in effect, it flattens expectations and possibilities for nurses' working days. It works to shift the discussion away from working conditions and content to which length of shift works best for someone's schedule. For the history of labor struggles, the length of the working day has been a focus of struggle, so when and how did a longer but less frequent working day becomes a victory?

In this article, after a brief discussion of my methods, I will present a brief history of the neoliberal shift in health care since the 1970s. Then, drawing on interviews with nurses and conversations posted on a popular nurse online discussion board, I question what the dominance of the 12-hour working day means for nursing. I examine what nurses are saying about the 12-hour shift structure, and, turning to Marx and Marxist feminists, I argue that this restructuring of nurses' work time is an important neoliberal tool that distracts from struggles over improved working conditions and patient care.

Methods

This article grows out of an initial project that explored the lives of a small group of migrant nurses working in the US. While in that initial project I did not set out to explore the structure of nursing shifts, it quickly became clear that the 12-hour shift was an important part of nursing in general. Thus, I followed this thread to both more nurses and to discussions on a popular online nurse discussion board. I draw on interviews with 15 nurses working in the US. These

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nurses are all at different points in their careers. They range from recent graduates to nurses in the middle of their careers to retirement age nurses. Three of the 15 interviewed nurses received their initial nurse training abroad and migrated to the US for work and further education.

Additionally, I have complemented these interviews with a discourse analysis of nursing online discussion boards on a popular nursing website. The website is a news forum and discussion space for nurses and nursing students, with over 750,000 members. I analyzed 25 discussions from 2004 to early 2013 in which nurses voiced their opinions on 12-hour shifts. Discussion board topics were all similar, with users beginning the board with question such as "Working 12-hour shifts — good or bad?", "Are 12-hour shifts too long?", "How do the rest of you feel [about 12-hour shifts]?", and "Am I the only one who hates 12-hour shifts?" Most discussions had between 10 and 60 participants, and the vast majority of participants only posted one (and sometimes two) comments. I coded the participants according to how favorably, unfavorably, or ambivalently they expressed feeling towards 12-hour shifts and then coded them for themes that qualified nurses' like, dislike, or ambivalence.

The anonymity of online discussion boards presents limitations for the research. For example, unlike in interviews, I am limited to the single or few comments a participant posts. Also, though I cannot filter participants by characteristics such as race, age, specialization, gender, and location, many participants offer some of these details or the discussion itself is among nurses in a particular location, specialization, or combination of the two. Thus, my discussion in this article largely applies to hospital nurses, given that they constitute most of the participants and most of the nurses who work 12-hour shifts.

Also, these discussion board conversations are among colleagues, and this changes the relationship a researcher has with the participants. These public discussion boards, however, constitute a useful and important site for understanding how nurses view their jobs. They provide a window into discussions that colleagues have with one another — discussions that are different from that of the researcher and the interviewee. Given the popularity of the website and the evident emotion with which nurses discuss their shifts, these discussion threads provide important complementary information on the issues nurses face within shift work.

Nursing as social reproduction and the social reproduction of health care

Nursing is public reproductive labor (Nakano Glenn, 1992). It is paid reproductive labor done generally outside of the home, in a space that is not quite public and not quite private — the clinic, the hospital room, the nursing home, and the home-turned-care facility. Similar to the reproductive labor women perform in the private spaces of the home, public reproductive labor involves social activities, both intimate and not, that reproduce daily life. This labor is the feminized, historically unpaid or under-paid, and invisible work that women have done to reproduce the productive male laborer.

It is not to capitalism's advantage to pay for social reproduction. The commodification of care does generate capital – indeed, billions of dollars – but, just as with the exchange of productive labor-power, capitalism strives to lower the cost of social reproductive labor power as much as possible. Capitalism is in luck though, because in social reproduction it created a type of productive labor that is hidden and easily cheapened through feminization and disguise (Fortunati, 1995). Through centuries of force, coercion, and structural changes, capitalism created a clear division of masculine-productive labor that went on the market for a wage and feminine-reproductive labor that at first glance had no market value (see Federici, 2004 for a history of the gendered division of labor in primitive accumulation). Social reproductive labor was then hidden away in the privacy of the home, no longer categorized as work but instead as the 'natural' activities of women. But social reproduction *is* work and is central to the production and reproduction of labor power. As explained (Dalla Costa and James, 1972, 11, emphasis original), social reproduction "is how labor power is produced and reproduced when it is daily consumed in the factory or the office. *To describe [labor power's] basic production and reproduction is to describe women's work*".

Leopoldina Fortunati argues that, "…reproduction *is* the creation of value but it appears *otherwise*" (1995, 8, emphasis original). Indeed, positing reproduction as non-value enables reproduction to function as the wageless production of value. Capitalism then does not see (re)production of workers as work, even though workers are latent labor power and profit. It is value produced for free, since social reproduction is 'natural'. Thus, this natural labor – social reproduction – appears economically valueless. When social reproductive labor becomes commodified – and since rather than directly producing surplus labor power and profits, it is labor that (re) produces potential labor power – it is at an even greater disadvantage on the market than productive labor is, subject to more devaluation through its historical position as 'women's work'.

Nursing is a special form of social reproduction. Nurses' work is a combination of nurturant care work and technical skill and scientific knowledge, a combination that has historically created tension in the profession, with nurses split on whether nurses' primary roles are to nurture or to perform technical skills (see Reverby, 1987 and Duffy, 2011 for an overview of this tension). Regardless of which side is emphasized, nurturing – or 'women's work' – is still an essential part of nursing identity and work (Clark Hine, 1989; Duffy, 2011; Malka, 2007; Reverby, 1987). The 'women's work' of nursing repairs the worker for re-entry into the market at their most efficient. Nurses support people when at their most vulnerable, educate communities, and fill both medical professional and mothering roles. The nursing profession is the backbone of the entire healthcare system, because nurses to do the hands-on body work of health care, are commonly the health care workers patients see most frequently, and perform the support work for doctors. Albeit this happens in an increasingly stratified way as tasks are divided among the strict hierarchy in nursing that rests on class differences and systemic racism (see Clark Hine, 1989 and Nakano Glenn, 1992).

Additionally, the social reproduction of the hospital or clinic mirrors the social reproduction of the household, complete with gendered hierarchies of professions just as with gendered hierarchies of paid versus unpaid labor in the