# Social Differences among Nurses and Physicians in Switzerland: An Intersectional Perspective

**To debate:**

- **Social categories influence nurses' and physicians' positions within hospitals.**
- **The feminisation of medicine is a fact, but women still face a glass ceiling.**
- **The training of nurses has changed leading to differentiations and specialisations.**
- **Since 2010, Switzerland tries to diminish foreign-trained nurses and physicians.**

**The specialisation of physicians but also of nurses is steadily increasing. What kind of tasks a person accomplishes within a hospital does not only depend on formal qualifications, but also on social categories such as gender, age, and migration as well as informal skills like work experience, language knowledge or one's assertiveness.**

From left to right:

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## A study with an intersectional perspective on hospitals as institutions

For some years, the development of the Swiss health care system has, as in many other countries worldwide, been driven by neoliberal processes such as privatisation, commercialisation, new forms of payment such as the flat rate per case *(Fallpauschale)* as well as management principles of economic efficiency and quality assurance. As the economisation of health care proceeds, there are discussions in many areas of the system such as the debate on costs per patient, the outsourcing of services and the general staff shortage that are directly linked to care and medical treatment.

At the same time, the professional fields of medicine and nursing are highly structured by social categories such as gender, age, qualification, work experiences, language skills and migration. In the institutions of hospitals, these categories often constitute the basis for the way in which implicit and explicit skills are ascribed and recognised. The ascription and recognition of difference translates into power geometries: questions of power, hierarchies and responsibilities. Neoliberal management in hospitals can use these categories in various discriminatory ways. Such practices include clauses of sole commitment to the hospital, payment lower than the professional standard, temporary employments and no payment for overtime work (Kunkel 2014).

The interdisciplinary project "Employment and Social Differences in the Swiss Health Sector" aims to unveil social diversities in the health care labour market by contextualizing and localizing the institutional logics of personnel policy within hospitals in a situation of staff shortage and under the pressure of neoliberal restructuring. We conduct an institutional ethnography (Smith 2005) of a Swiss acute hospital to understand the institutional logic and ruling relations that shape personnel policies in this specific place. This perspective is combined with a multilevel intersectional lens (Winker & Degele 2009) to capture how personnel policies are structured by categories of social difference. With this perspective, we trace power geometries based on differences such as gender, age or migration. Both approaches, institutional ethnography as well as intersectionality, represent feminist theoretical and methodological perspectives in research and allow to analyse power, inequalities and their making in socio-spatial contexts.

For this study, we follow two strategies of data collection, one outside and one inside the hospital: Outside the hospital, we do expert interviews with stakeholders in the field and conduct open semi-structured interviews with a variety of healthcare professionals, such as physicians and nurses or representatives from professional organisations. In addition, we collect media articles, governmental documents and reports by different actors and organisations within the healthcare sector. Inside the hospital, we do an institutional ethnography that involves doing observations by shadowing nurses and physicians in their daily work in three different wards, collecting documents and conducting open semi-structured interviews with members of the middle and senior management.

The study seeks to contribute to the field of research on social inequality in the labour market, with a special focus on gender issues, using an institutional perspective. Combining the research strategies of an institutional ethnography and multilevel intersectionality constitutes a novel approach to the research questions. By structuring our study in this way, we aim at enriching the debate theoretically and methodologically. For practitioners, the results will have implications in terms of management strategies, hierarchies and power structures. By closely analysing social diversity, practitioners will gain novel insights for their equal rights policies, for concepts on gaining as well as retaining health care staff and questions regarding personnel shortages, especially in relation to working conditions, job satisfaction and work-life balance.

## Changes amongst physicians and nurses in terms of gender and education

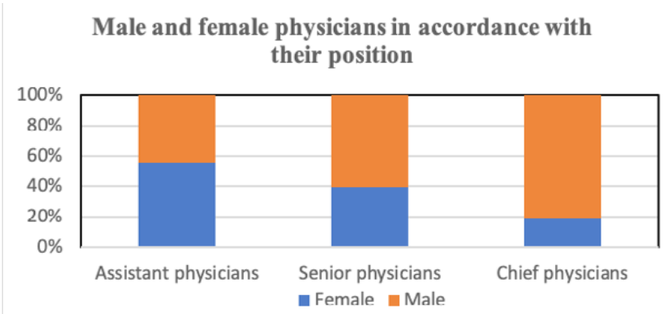
When looking at the intersection of various categories of social difference, several points emerge: For a long time, and to a certain degree this is still persisting, physicians have been overwhelmingly elderly and male. Within the hierarchical organisations of Swiss hospitals, they had powerful, prestigious, and well-paid positions; and they bore the full responsibility for the patients. Nurses, in contrast, have been predominantly female. They were badly paid, had a low status and not much decision-making power. While the images of the omnipotent physician *(Halbgott in Weiss)* and the devotedly caring nurse are partly still existing, things are slowly changing – especially during the last two decades.

*"Why should only women have a problem with reconciliation? [...] The problem is that the general culture in the medical fields is male dominated.»*

**Female consultant, interview, 2018**



Regarding the physicians, two partly interrelated issue have led to major alterations. First, the feminisation of the medical profession. Since 2005, more women than men finish their medical studies in Switzerland. While there are now more female than male assistant doctors, their proportion radically diminishes the higher the hierarchical level (Kraft & Hersperger 2009). This leaky pipeline (see diagram 1) has structural and socio-cultural causes (Schädeli 2017). Second, the so-called generation y, that is people born between the early 1980s and the early 2000s, has a different understanding of what it means to be a doctor than those who are in their fifties or sixties. While for the latter, their profession is mostly a vocation, meaning that working seventy hours a week is considered as normal, the generation y aims at having a better balance between work, family and leisure (Schär in VSAO 2014). Today, more and more female but also male physicians aim at working part time, ask for child care possibilities and better working conditions. In this regard, several cantons have signed a collective employment agreement for hospitals in the last years, for example Aarau in 2017 and Bern in 2018. The latter also includes a paragraph on pregnancy protection and maternity leave.




Male and female physicians in accordance with their position in 2010. Source: OBSAN 2012: 5.

In the last twenty years, the profession of nurses has undergone major changes, especially in terms of training. Today, there are different trajectories, from a two-year apprenticeship (*Assistent/in Gesundheit und Soziales EBA*) to a three-year vocational training (*Fachfrau/-mann Gesundheit EFZ*), specialised schools (*Höhere Fachschule*), universities of applied sciences (*Fachhochschulen*) up to Bachelor, Master and PhD degrees in nursing science from universities. This leads to a high differentiation within the nursing profession which has concrete practical consequences such as a lack of clarity regarding competences, skills, roles and the collaboration amongst nurses, as not all are trained in the same way and are able and allowed to conduct the same tasks. As a result, the grade and skill mix within a ward has become more and more an issue *(Horisberger 2013)*. Furthermore, nurses increasingly ask for better working conditions, higher salaries and the recognition of their work. In November 2017, the Swiss

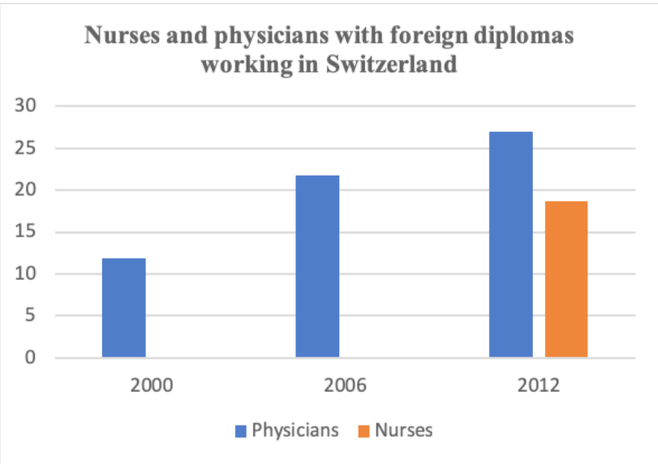
## Federal popular initiative on care work

(Pflegeinitiative, www.pflegeinitiative.ch)

The association of care workers launched a federal popular initiative on care work in 2017. The initiators push mainly two claims: Firstly, the Confederation and cantons will be compelled to secure sufficient health care provision. Secondly, care workers will be allowed to prescribe care measures and to square those separately with the health insurance funds. Opponents of the popular initiative argue that billing of care workers would raise health costs. Moreover, the hinge function of the physicians within the Swiss health care system would be weakened, leading to reduced patient's safety. Currently, the Federal Council draws up a dispatch for the parliamentary debate, before it comes to popular vote.

professional association of nurses submitted a popular initiative with the aim to increase the attractiveness of their profession and to take effective measures against the personal shortage of nurses *(Pflegeinitiative, see information box 1)*. Altogether, the described changes aggravate the staff shortage and the competition among the hospitals for the best physicians and nurses and have thus far-reaching consequences for hospitals as organisations.

In sum, gender shapes the field of medical professionals to a great extent when it comes to the dividing line between professional groups (nurses vs. physicians) but also when it comes to career possibilities in both groups. This results not only in a gender gap between professions but also in a male dominated working culture among physicians with emphasis on long working hours, full time employment and commitment to the profession.




Nurses and physicians with foreign diplomas working in Switzerland. Source: OECD 2016: 108-109.

## The health care shortage and migration of nurses and physicians to Switzerland

The Global North needs more and more health personnel to cure and care for their ageing population. At the same time, patients have higher requirements and the availability of possible treatments increases. In Switzerland, the individual hospitals determine recruitment practices. In the last two decades, hospitals have faced major challenges in relation to a severe shortage of personnel, in particular in the area of nursing. The shortage is even more acute in long time stationary institutions such as in nursing homes. Consequently, health institutions have heavily recruited foreign-trained medical and nursing personnel. Between 2002 and 2008, the percentage of foreign-trained healthcare personnel working in Switzerland – coming mostly from the European Union – has steadily increased *(Diagram 2; BAG 2010: 5)*. Within the European Union, medical and nursing degrees are recognized automatically. Based on the bilateral agreements between the EU and Switzerland, this recognition also applies to the Swiss case where the Swiss Red Cross is responsible for the recognition of foreign nursing diplomas. For being officially permitted to work in Switzerland as a nurse, the equivalent of the training and/or a certain level of professional experiences must be proofed. Additionally, the applicant must dispose of a language certificate in German or French respectively at the international B2-level (*www.redcross.ch* 2018).

In 2009, the Conference of Cantonal Health Directors (GDK) and OdASanté, a national umbrella organisation of the healthcare sector, published a study on the future requirement of health professionals in Switzerland. It showed an increase of staff shortage in the coming years, especially regarding nurses. This led the Swiss government – together with the GDK and OdASanté – to design a national strategy with the aim to train more nurses and physicians in Switzerland to be less dependent on foreign healthcare personnel (BAG Gesundheit 2020).

On a global level, the nurses and physicians' migration has severe consequences for the regions of origin: While countries of the Global North import health professionals, countries of the Global South are left with a severe staff shortage. In 2010, the WHO produced a Global Code of Practice on the International Recruitment of Health Personnel (resolution WHA63.16, see information box 2) to counter this 'care drain'. Switzerland does (with some exceptions) not directly recruit nurses and physicians in countries of the Global South, but engages health personnel for example from France and Germany that then again hire their staff for example from former African colonies or the Philippines. Thus, Switzerland with its generally high wages and good quality of life, plays an important role in this migration chain. Since the signing of the WHO codex – and also due to the pressure that arose as a consequence of the so-called mass immigration referendum's acceptance (*Masseneinwanderungsinitiative*) –, the different actors within the Swiss healthcare system increasingly recognise the global dimension of staff shortage and Switzerland's critical role therein *(Leschhorn Strebel 2012)*.

In this sense, the health care labour market is strongly structured by the intersection of gender, age and migration, which results in often conflicting interests of different players and asymmetrical power hierarchies.

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## WHO Global Code of Practice on the International Recruitment of Health Personnel

In 2010, the WHO Member States – amongst them Switzerland – adopted the Global Code of Practice on the International Recruitment of Health Personnel with the aim to promote ethical principles. Member states are encouraged to form their own health personnel and to not actively recruit them in countries with a shortage of health workers. Furthermore, the code stipulates the equal treatment of foreign and domestic health personnel. In 2017, the large majority of acknowledged foreign medical doctors came from Germany followed by Italy, France, Austria and Romania (BAG 2017).



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