TRENDS AND PERSPECTIVES IN THE NURSING PROFESSION:

Nurse employment during health care reform: The case of the United Kingdom by Christine Hancock, James Buchan and Phil Gray

Les infirmières et le personnel auxiliaire dans les hôpitaux publics et privés belges par Cécile Fontaine

The future of the nursing professions: rethinking health care work in North America by Sholom Glouberman

Successful strategies for developing leadership among nurses by Tom Keighley

Working papers are preliminary documents intended to stimulate discussion and critical comment

International Labour Office Geneva
Foreword

Through its Sectoral Activities Programme, the ILO assists governments and employers’ and workers’ organizations to strengthen their capability to deal equitably and effectively with labour and social problems specific to different sectors, industries and occupational categories. Over 30 industries or sectors receive specific attention through several subprogrammes dealing with: manufacturing, basic industries and transport; maritime industries; the service sector, including salaried employees and professional workers; and hotels, catering and tourism.

A major means of action is the holding of meetings of tripartite (governments, employers, workers) Industrial Committees, each of which is composed of selected countries that are representative of the sector with which that committee deals. Some of these are standing committees, others are convened on an ad hoc basis. In addition, bipartite meetings (governments, workers) and meetings of experts are held to consider labour and social problems of specific occupational categories.

In support of the meetings programme, the Sectoral Activities Department acts also as a centre for the collection, analysis and dissemination of technical information. Studies are carried out on issues of concern to particular industries and sectors. Such studies also support a wide range of operational activities in the form of technical cooperation and advisory services.

This publication is the outcome of research carried out under the Sectoral Activities Programme.
Preface

Health care personnel form one of the most important occupational groups for society. They are essential in maintaining and improving peoples' living conditions and health, most of the time offering immediate services in direct and close contact with the client. Working conditions, job satisfaction, equality concerns and other factors are crucial in attaining high levels in quality of recruitment, performance and, most importantly, the delivery of services, i.e. the success of the occupational activity to the satisfaction of all persons involved. At the same time, these factors also determine the professional status of health care workers in all countries.

The International Labour Office has been engaged, as early as the 1930s, in various research and standard setting activities on medical and health care professions. More recently, the Governing Body of the ILO established a Standing Technical Committee for Health and Medical Services which held its first meeting on 23 September-1 October 1992. In its research, the ILO has put emphasis on the analysis of the working conditions of nursing personnel in many countries, particularly in the report devoted to Equality of opportunity and treatment between men and women in health and medical services1.

A research project carried out at the request of the Governing Body in 1990-1992, resulted in two major studies, undertaken by the Salaried Employees and Professional Workers' Branch on remuneration of nursing personnel, both published in 1994.

The first one by Mr. D. Marsden on *The Remuneration of Nursing Personnel: An International Perspective*2, consists of eight case studies, together with a comparative analysis, covering all categories of personnel in treatment and nursing services. The countries covered are: Canada, Denmark, Egypt, France, Ghana, Philippines, United Kingdom and United States. The second study by Mr. A. Brihaye on *Nurse Pay: A Vital Factor in Health Care*3, covers some 40 countries, the majority of them developing countries. Drawing on the above-mentioned case studies and on information supplied by governments, national employers' organizations and international agencies, this study focuses on the situation of nursing personnel with regard to remuneration, taking into account employment trends, basic remuneration concepts from a tripartite perspective, real earnings and the positions of the parties concerned by the material condition of nursing personnel (representative organizations of nursing personnel; public authorities).

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The present compilation of four shorter papers on nursing personnel covers specific subtopics viewed from different national perspectives (United Kingdom, Belgium and the United States). The first study by Ms. Christine Hancock, James Buchan and Phil Gray of the Royal College of Nursing (U.K.), examines Nurse Employment during Health Care Reform: The Case of the United Kingdom. The current programme of reforms in the National Health Service is analyzed from a labour market point of view, and includes characteristics of cost effectiveness of nursing staff levels and skill mix changes; nurse employee relation and unionization; nurses' pay determination; job satisfaction; and future prospects of reform.

The second study by Ms. Cecile Fontaine, Director of the nursing and human resources department at the Ambroise Paré hospital in Mons, Belgium, on the situation of Nurses and Auxiliary Staff in Public and Private Hospitals in Belgium (Les infirmières et le personnel auxiliaire dans les hôpitaux belges), deals with career development and positive action programmes. Despite a general deterioration of working conditions due to budgetary cuts in many hospitals, the analysis confirms positive effects of redistribution of tasks between the two categories (professional nurses and assistant staff), and it evaluates options for career development supported through positive action for women.

The third study by Mr. Sholom Glouberman, Assistant Professor in Health Administration for the Faculty of Medicine at the University of Toronto (Canada), Philosopher in Residence at Baycrest Centre for Geriatric Care, Advisor to a number of Health care Organizations in Canada and the UK and Associate Fellow at King's Fund College, London, England, entitled The Future of the Nursing Professions: Rethinking Health Care Work in North America, adopts an original approach in assessing the different "faces" of health care that consist namely of cure, control, community and care. It further identifies the role of nursing professionals in each scenario, and describes three options for the future development of the US health care system: to remain as it is (no changes option); to shift toward community-based health care; or to rethink current roles and processes in order to reorient health services to changing needs. The author considers a mixture of these to be the most likely option.

Finally, the study by Mr. Tom Keighley, Director of the Institute of Nursing, Leeds University (U.K.), discusses Successful Strategies for Developing Leadership among Nurses. Leadership and management issues are dealt with as effective instruments to improve patient care, both from an European and a North American perspective. The study calls for a professional approach to the development of leaders in nurses, in order to promote leadership that would aim at shifting values within the traditional power structures in health care occupations.
Change and reform are the underlying themes of all the four studies introduced here. This publication offers a platform for discussion of these various elements that potentially help to develop the nursing profession and to improve working conditions of the health care staff in different countries. This effort is also being made in reply to the conclusions and resolutions of the First Session of the Standing Technical Committee for Health and Medical Services.

Readers’ comments will be welcomed.

March 1995

Hedva Sarfati,
Chief,
Salaried Employees and Professional Workers Branch.

\[\text{Note on the Proceedings, Standing Technical Committee for Health and Medical Services, First Session (23 September-1 October 1992), Geneva, 1993.}\]
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PART I. Nurse Employment during Healthcare Reform: The Case of the United Kingdom by Christine Hancock, James Buchan and Phil Gray

Introduction

This paper examines the impact on nurse employment of the current programme of reforms in the National Health Service (NHS) of the United Kingdom. The paper is in three main sections:

- the process of reform and the impact on employee relations in the NHS (chapter 2);
- the nursing labour market in the United Kingdom and the impact of reform on the employment of nurses (chapter 3);
- prospects for future change (chapter 4).

1. The National Health Service Reforms

The 1988 review of the National Health Service (NHS), which led to the NHS and Community Care Act 1990 and the implementation of the reforms in 1991, was a political reaction to a series of high profile NHS resourcing problems. A number of these problems related to nurse staffing, such as the shortage of specialist nurses at a Sick Children Hospital in the English Midlands. Solving the problems of skills shortages and securing improvements in employee "productivity" have been central tenets of the NHS reforms.

The NHS is a labour intensive service industry: it is estimated that salaries and wages of staff directly employed by the NHS in England represented 76 per cent of health authorities' net revenue expenditure in 1990 [OHE, 1992]. The workforce is large (more than one million are employed in several hundred establishments), is heavily unionised with several powerful professional and generalist unions. Nursing represents the largest element of the workforce, with more than 300,000 qualified nurses in employment. The Royal College of Nursing is the largest union for nurses.

Although the NHS is labour intensive, the pre-reform NHS relied on centralised national negotiations of terms and conditions of employment, with local activity primarily being "hiring and firing" and dealing with individual grievances. Other activities (for example, training and development and manpower planning) varied markedly in depth and effect in different health authorities [for a detailed discussion of pre and post reform human resources, see Buchan and Seccombe, forthcoming].

The NHS reforms of the 1990s were preceded by the "Griffiths" reforms of the 1980s. The Griffiths (1983) reforms of the mid 1980s replaced consensus management with general management, and a teams of four senior officers (nurse, administrator, doctor and accountant) with a single general manager who had overall accountability and responsibility for the management of services in the health authority. Griffiths also marked the beginning of an increased role for the personnel function:
"Devolution in personnel matters will imply a strengthening of the personnel function at each level and its close support of line management."

Personnel "officers" became "managers" or "directors": the human resource planning of medical and nursing, previously often dealt with separate functions, began to be amalgamated and integrated with planning and other staff groups and the focus of the personnel function began to shift from a primarily advisory role to one that was part of a corporate "business" team. Just as Griffiths signalled the importation of private sector business management principles, it also represented the beginnings of the establishment of private sector human resource management practices. In summary, the Griffiths reforms of the 1980s provided the structural changes necessary to enable the organisational and cultural changes implicit in the reforms of the 1990s. Devolution of responsibility in the management of human resources did not begin with the reforms of the 1990s: the Griffiths restructuring had already begun the process by the mid 1980s.

The process of change in the NHS, begun with the implementation of the Griffiths recommendations, was accelerated by the publication of the key White Paper "Working for Patients" in 1989. This paper was the blueprint for the reforms of the 1990s. There were three central elements of the reforms:

- decentralisation of responsibility (including a move from central to local pay determination);
- the establishment of self-governing NHS Trusts; and
- the introduction of the "purchaser/provider" split.

All have significant implications for the management of labour costs and of NHS personnel. One of the driving forces behind the reforms was improved cost containment and, in this context, labour costs as the major element of expenditure constituted an obvious area for improvement in terms of "value for money". However, there was little specific guidance in the content of the Act as to how these changes were to be implemented. There was little mention of nursing or other non-medical employment issues, and few considerations of employment practice. Beyond the general assumptions built into the reforms that devolution, decentralisation and flexibility should be articles of faith in the post-reform management of NHS staff, there was no detailed blueprint for change. Indeed, such an approach would have cut across the grain of the reforms, which places the emphasis on local managements' "right" and responsibility to manage.

Against this background of centrally driven reform, nursing organisations and unions have had to meet challenges of representing the profession and individual nurses in a rapidly changing environment. The impact of these changes on the employment of nurses will be discussed in the next section.

2. The Reforms and Nurse Employment

This section describes the labour market for nurses in the United Kingdom and reviews the impact of the reforms, on three key aspects of nurse employment - staffing levels and
mix, employee relations, and pay and conditions. Consideration is also given to the impact of reforms on job satisfaction and career prospects of nurses working in the reforming NHS.

2.1 The UK Labour Market for Nurses

The labour market characteristics and behaviour of qualified nurses received considerable attention in the 1980s, mainly because of concern about recruitment and retention. The UK nursing workforce is mainly employed in the NHS, but growing numbers are employed in the private sector in nursing homes. Key characteristics of the nursing workforce are:

- more than 90% are female;
- one third work part time;
- average age is approximately 39.

There is no single national labour market for nurses, but rather a series of interlinked and overlapping geographical and skill based labour markets of varying sizes and dimensions. The age, gender, marital status, career history, basic and post basic qualifications and employment status (full or part time) of each individual nurse all play a part in determining in which labour market she or he is located.

This labour market system is dynamic, as the labour market characteristics of individual nurses may change over time, and their labour market behaviour may alter. For example, a young, single nurse working full time, and with post basic specialist qualifications is likely to occupy a larger market (in geographical terms) than does an older nurse with domestic commitments, who works part time. Rather than dictating a single, readily defined labour market, the varied characteristics of individual nurses act to create a more fluid situation, with a series of interlinked labour markets of differing dimensions, with significant flows of nurses between these markets, as well as to and from the profession itself.

2.2 Competing Demand for Nurses

There are over 600,000 qualified nurses and midwives registered with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, the registration body for the professions. This is the "pool" from which the NHS, and other employers must recruit qualified staff. More than half of the total pool of nurses are employed in the NHS. A detailed picture of the disposition of qualified nurses in other forms of employment is difficult to establish. In England, in the late 1980s, it can be estimated that at least 68,000 qualified staff were employed in non-NHS employment, mainly in private sector nursing homes [Buchan, 1992]. In overall terms, approximately four times as many qualified nurses work in the NHS than in all other forms of employment combined. However, it should be noted that General Practitioner (GP) practices and the nursing homes are growing rapidly in importance as sources of employment of nursing staff. Department of Health data suggest the number of qualified nursing staff working in the independent sector has doubled in the 1980s, and the number of practice nurses has tripled, whilst NHS employment has remained static since the mid-1980s.
The dominance of the NHS is further emphasised when it is noted that all but 95 of the 19,688 training places for first level of the training are NHS based [Department of Health, 1991]. The NHS is both the major educator and employer of nurses.

The "monopsony effect" of the NHS has important implications for the labour market behaviour and for nurses' pay. As the dominant employer, NHS pay rates have dictated what the "market rate" for nurses pay will be, rather than the "market" dictating what NHS nurses pay should be. The envisaged move from a single national NHS rate to local variations in NHS pay rates may complicate this situation. However, in economic terms, at both national and local level, the NHS is likely to continue to exert near monopsonistic power in purchasing the services of qualified nurses - that is, it will nearly always be the major employer, and often will be the only employer of nurses in a specific labour market.

The implementation of the NHS-Act in April 1991 has created a situation in which there are several hundred directly managed units (DMUs) and Trusts, each acting as an employer. In many labour markets, the major competition for nurses will be between NHS units, rather than with other, non-NHS employers. In particular, in larger conurbations and metropolitan areas, several DMUs and Trusts may be competitors in recruiting and retaining nurses.

2.3 Nurse Staffing Levels and Mix

The post-reform creation of provider units - directly managed units and self-governing NHS Trusts - has established several hundred employing units who had greater "freedom" (in theory, at least) in determining nurse staffing levels and mix than had the pre reform district health authorities and boards. NHS Trusts in particular, had quasi-autonomous status.

In the new market for health care, providers' income no longer derives directly from central budgets but from purchasers choosing to buy their services. Competition in this market will, initially at least, be based largely on cost comparisons. The key requirement for management in provider units will be to achieve reductions in their costs, so that they remain competitive. The importance of labour costs (which are three-quarters of total cost) has focused attention on staffing levels, mix and unit labour costs. Nursing, which represents the majority of staff in most units, is therefore coming under cost-based scrutiny.

In relation to nurse staffing levels and staffing mix at local level, the effect of the reforms is less about dismantling bureaucracy than about stimulating local management to review custom and practice and historical staffing partners, with a view to achieving better "value for money". In this context there has been continuing tension between those nurses and other health care professionals focusing on patient care, and those managers responsible for cost-effective use of resources but constrained by a lack of clinical knowledge. In combative language, this has sometimes been characterised by managers as "taking on the professions", or ending "professional tribalism".

Many employing units are instigating "skill mix reviews" or are attempting to "reprofile" their nursing workforce. These activities have sometimes led to conflict with nursing organisations representing staff being scrutinised in these reviews. There is increasing debate about the impact on quality of care provided of some of the skill mix changes which are occurring, and some evidence that there is the beginning of a declining trend in the number of qualified nurses being employed in the NHS.
The latest information from the Department of Health shows a decrease in the whole time equivalent nursing workforce in Great Britain. Between September 1991 and March 1992, there was a reduction in both qualified and unqualified staff numbers. The whole time equivalent (wte) for qualified staff reduced by 5,235 (-1.68 per cent) while for unqualified nursing staff the reduction was 1,401 (-1.23 per cent). The reduction in the number of pre-registration students with employed status, i.e. those who make a service contribution of 60 per cent compared to the 20 per cent contribution from Project 2000 students, was 7,205 (-15 per cent) ["Project 2000" is a new form of nurse education being introduced in the UK].

Owing to changes in the presentation of staffing figures, it is not possible to compare the latest figures with earlier workforce statistics. However figures published earlier have also shown a decrease in nursing numbers. In the year to September 1991, there was an overall reduction of 0.8 per cent in the total nursing workforce, while since 1986 there has been a reduction of 1.3 per cent in nursing whole time equivalents [Department of Health Statistical Bulletin, 1/93, March 1993].

There have also been redundancies of nursing staff in post in various units. While the numbers of nurse redundancies announced so far have been small in relation to the size of the workforce (the RCN estimates 1,200 nursing posts have been declared redundant since the beginning of 1993), the impact on the morale of nurses has been marked, with many exhibiting deep concern about their job security.

These staffing level reductions and redundancies have been occurring against a backdrop of continued increase in the workload of nurses in the NHS. Latest data from the NHS in England shows that between 1900/91 and 1991/92:

- the total number of ordinary admission episodes rose by 3 per cent;
- total outpatient attendances increased by 2 per cent;
- the number of day cases rose by 23 per cent;
- throughput (defined as patient episodes per available bed) increased by 9 per cent [Department of Health Statistical Bulletin, 1992/3, February 1993].

Average length of stay of patients in hospital has also decreased, leading to an increase in the dependency level if inpatients and further increases in nurse workload.

There has been surprisingly little attempt to conduct a proper evaluation of the cost effectiveness of skill mix changes. Whilst the cost savings, in terms of reduced paybill can be readily demonstrated, little attention has been paid to evaluating the broader impact on costs and quality in terms of employee productivity and effectiveness of care provided [Buchan and Ball, 1991]. Some research has indicated that there is a direct relationship between the grade mix of nursing staff used and measures of the quality of care with a "richer" skill mix leading to higher quality of care [Carr-Hill et al., 1992].

One possible constraint on further developments towards a less skilled or qualified, but "cheaper" NHS nursing workforce, could be the parallel drive towards lowering costs of patient care by reduced average length of patient stay. The achievement of higher turnover
of patients, with a higher average acuity level may place a limit on such skill mix changes, as there will be a requirement for highly skilled staff to treat high dependency patients.

It is in the area of changing nurse staffing levels and mix that the NHS reforms have had the most obvious impact during the early course of the reforms. As yet the overall impact of changes in staffing patterns and levels is difficult to assess, both in terms of changes in employee numbers and in terms of their effect on the level cost and quality of service being provided. Change is incremental with different units moving at a different pace, but in overall terms there are indicators of a trend towards a proportionate reduction in the qualified workforce.

2.4 Nurse Employee Relations

Employee relations in the pre-reform NHS were heavily unionised, with policy and procedure determined nationally and interpreted and applied locally. As with much else in the public sector, the employee relations system in the NHS was a post war development of the welfare nurses state, with Whitley Councils being established for the various staff groups. The largest union is the Royal College of Nursing, with other nursing staff being represented by a union (UNISON) and by a number of smaller specialist professional associations.

The Whitley system of national Councils was comprised of management and union representatives. Little changed from the inception of the NHS in 1948 until the implementation of the reforms in the 1990s. At the time of writing, the Councils remain in place and with much of their centralised power intact. Often characterised as unwieldy, unresponsive and overly bureaucratic, the Whitley Council system has been a major target for criticism and has occasionally been the target for reform [see, for example, McCarthy, 1976]. The whole thrust of the current reforms, with their emphasis on local management's right and responsibility to manager, the anti-bureaucratic language, and the "freedom" given to self-governing Trusts to establish their own local employee relations machinery, reflected political and managerial frustration with the lack of national political control and local managerial influence over the Whitley system.

Whitley is an easy target for criticism and jibes about bureaucracy, yet the implementation of the reforms has seen no rapid move away from its sphere of influence. This is perhaps unsurprising, given some of the checks incorporated in the NHS Act (for example, NHS employees whose workplaces become self-governing Trusts have the right to remain on Whitley terms and conditions), but also reflects a pragmatism at local level which is not required by national level politicians and civil servants. If the influence of Whitleyism is to be reduced, or ended, some alternative system for employee relations has to be in place.

In an organization where centralised negotiations have been institutionalised, and where there has previously been little requirement to develop local level collective representation skills such changes cannot happen overnight - even if all the parties involved were to regard such developments as desirable. Initial opposition to such developments from unions, and a "wait and see" approach by some managers prior to the results of the 1992 General Election also acted to slow the pace of change.

The main effort of local management activity in employee relations has been directed at simplifying the processes involved. This activity has mainly been directed at establishing
"single table" recognition agreements, where all employee relations activity is conducted in one forum, with a limited number of union representatives (in some cases full time officials being excluded or having observer status only). Often it has been left to the unions have to decide which of their representatives will sit at the "table", and where this isoccurring it is often the small specialist professional associations who are losing out.

Even with political and labour market conditions weakening the stance of the unions, most local managers are tending to adopt a pragmatic and long term approach, rather than going for radical short term change or attempting to derecognise unions. New recognition agreements tend therefore to reflect Whitley in terms of the number of staff groups recognised. The most significant changes in approach to employee relations have tended to occur in Trusts which are smaller and simpler in terms of staffing numbers and mix - for example, the ambulance service Trusts and community or priority service units.

This reflects most managers' pragmatism in adopting an incremental approach which can more flexibly respond to changes in the political and labour market climates and which can be accelerated when circumstances allow an increased pace of change. Reporting on plans for change in employee relations for nurses, Buchan (1992) noted that:

"No trust or directly managed unit is a green field site on which a new industrial relations culture and pay determination process could be set up on April 1st 1991. Organisational status may have changed on that date, but the organisational politics, the personalities industrial relations custom, practice and history remain."

However, most managers were planning for change:

"Main stated objectives of (personnel managers) was to reduce the number of recognised trade unions, to simplify local procedures, and to limit the bargaining rights of unions. Some managers stated their long term aim was to end collective representation of the workforce and to deal with employees on an individual basis" [Buchan, 1992].

2.5 Nurses Pay

NHS nurses’ pay has, since 1983, been determined by an Independent Review Body, which takes annual evidence from nursing unions, including the Royal College of Nursing, and from management. It then makes independent recommendations on pay increases.

The NHS reforms of the late 1980s raised the prospect of a fundamental move away from this centralised approach to determining nurses’ pay, both as a result of the setting up of self-governing Trusts, and because the focus on labour costs stimulated by the purchaser/provider split was bound to increase demands from local management to have greater control of paybill size and allocation. Further stimulus came from the Patients Charter, which emphasised the need for the pay of NHS employees to be more closely linked to local performance [Department of Health, 1991].

As with NHS employee relations systems in general, the post reform pace of change in the ways NHS nurses pay is determined has probably been slower than those responsible for the reforms would have envisaged or would have desired. A minority of Trusts have begun to establish performance pay schemes, or are moving towards a single pay spine for
all groups of employees, but most units - both Trusts and directly managed units, continue to pay Review Body rates to all nursing staff.

The RCN estimates that by mid 1993 only ten NHS employing units of the several hundred in the NHS have introduced their own rates of pay for nursing staff. In five cases these non-Review Body rates have been negotiated with local union representatives, including RCN officials, but in three of these five units local negotiations have led to additional increases for the lowest paid nurses, or to the use of Review Body recommended pay scales as the basis for introducing an element of performance related pay.

The overwhelming number of nurses employed in the NHS continue to have their pay and conditions determined through a national process. A number of factors can be identified which explain the slow pace of change away from the Review Body system.

Some have argued that a "looser" labour market during economic recession, and the increasing flexibility being incorporated into Whitley and other NHS pay settlements already enables Trusts to respond effectively to local pay pressures, thus mitigating against any immediate need to depart from national pay settlements.

In examining the stimulus for change in nurses’ pay determination, Buchan (1992) identified two major constraints on rapid change: funding limitations and the absence of "in house" capabilities in many local personnel management departments to manage the complexities of local pay determination.

Any attempt to establish a new pay structure, separate from Whitley can be an expensive exercise, particularly if there is an attempt to consolidate the pay of all NHS occupations on a single pay spine. Performance pay can also raise both employee expectations and the overall paybill. The Patients Charter argued that performance pay should be funded out of efficiency savings and without recourse to additional central government money, but the public sector pay restraints have imposed a low ceiling on any new activity in pay determination.

In the pre-reform NHS, there was no requirement for local NHS personnel departments to have significant capabilities to determine pay locally. The radical policy changes in human resource practice signalled by the NHS Act were not achievable in the short term, in practical terms. Pay determination at local level requires an expertise in negotiating, planning and maintaining pay and grading structures which was not evident in most NHS personnel departments - for the simple reason that such expertise had not been needed in the pre-reform NHS [Haywood and Vinograd, 1992].

These skills are now being rapidly developed, or acquired and it would be a mistake not to anticipate that the pace of change will now accelerate. Not only will practical expertise be increasingly available, and labour market conditions continue to be favourable to management, but the momentum to depart from standard, nationally determined, pay and conditions will increase as a greater proportion of NHS units achieve trust status. Ironically, the greatest, change in payment systems so far has been in the pay of the Trust personnel managers and other senior management colleagues, who are now paid on individual contracts with performance related supplements.
The key skills being acquired by NHS personnel managers as they prepare for a greater degree of local pay determination are in employee communication, negotiation, job evaluation, financial modelling and labour market analysis. In particular, a number of job evaluation schemes are being developed by different consortia of NHS personnel managers and management consultants. Trade unions are also preparing for the mid-1990s by training local stewards and representatives to have similar skills. The Royal College of Nursing, for example, is investing heavily in training local representatives and in developing databases and information systems to support local activists.

At the time of writing, changes in nurses pay determination as a result of the NHS reforms are more apparent than real. This may reflect the fact that existing NHS nurses have the right to retain their national pay and conditions, and the fact that recession has curtailed labour market pressure to set local rates at a higher level. There is little doubt, however, that the pace of change is likely to accelerate rapidly through the mid-1990s, as personnel departments acquire the skills to manage pay locally, as labour costs are increasingly the focus for management action, and as Trusts become the norm. The structures and skills required for local pay determination are being developed. When they are in place, activity is more likely to increase.

2.6 Nurses Job Satisfaction and Morale

Since 1987, the RCN has commissioned an annual survey of a large national sample of its nurse members. The results of each of these surveys has been provided to the Review Body as part of the pay determination process, and has been made publically available.

Each survey has researched aspects of nurses’ experiences in employment, focussing particularly on career plans and job satisfaction. The surveys provide a unique insight into the state of the nursing profession, and they enable monitoring of the impact of the reforms on NHS nurses.

In relation to nurses’ pay, the surveys have revealed that the importance of pay to individual nurses has increased since 1987. In the most recent survey [Seccombe and Ball, 1993], three quarters of nurses said that their earnings were critically important and for a quarter they were the only source of household income. The proportion of nurses who are dissatisfied with their pay has increased since 1987, with more than half those surveyed in 1993 that they felt they were not paid enough for their level of responsibility and experience.

Both the 1992 and 1993 surveys asked nurses to indicate the extent to which they agreed or disagreed with the statement: "Nursing will continue to provide me with a secure job for several years". There has been a dramatic shift in responses to this statement. In 1992, over half the respondents (52 per cent) agreed with the statement; in 1993, less than a fifth (18 per cent) agreed. This dramatic shift in attitudes clearly reflects the rapidity with which nurse unemployment and redundancy have become a major issue.

The current concern about job security is given further emphasis by nurses responses to the statement "I am worried that I may be made redundant". Over half (52 per cent) the NHS nurses agreed with this statement, with nearly one in five agreeing strongly in 1992. Enrolled nurses and senior nurses are particularly anxious about redundancy, and community nurses are more anxious about redundancy than their hospital based colleagues. For example,
nearly 70 per cent of health visitors agreed strongly with the statement. Nurse teachers are particularly anxious about job security, three quarters stating that they are worried about redundancy.

The RCN continues to be committed to commissioning independent and objective studies, including these surveys and other studies, such as a report on performance pay in nursing [Thompson and Buchan, 1992], because it believes that the complex issues of nurses' job satisfaction and career prospects will continue to require close scrutiny. The RCN believes that independent research adds weight to its arguments in support of nurses in the NHS - its track record in commissioning and publishing such independent work is far superior to that of other unions and to government.

3. Future Prospects

For some government ministers and senior civil servants the lack of rapid progress in devolving employee relations and pay determination has been a real frustration. Eric Caines, then Personnel Director of the NHS in England, in 1990, stated his hope that the Pay Review Bodies and Whitley Councils would have ..."come to the end of their life within 18 months to two years". Two years later in November 1992, both were still in place, causing Caines to comment:

"Somebody needs to kick the crutches away and tell Trusts to stand on their own two feet on pay. The central systems - Whitley Councils and Review Bodies - should be buried without delay. But ministers do not want to upset the professions or cause trouble with the unions. The professional organisations are the great problem of the next five years; its time to kill them off" [THS, November 1992].

Caines has since left his NHS post, but continues to criticise the "slow" pace of change from his new job in academia. As the pace of change increases, there is likely to be increasing organisational tension in attempting to maintain discrete but overlapping national and local employee relations policies and pay determination practice. As Buchan (1992) noted:

"Government ministers may express public commitment to the existence of the Review Body, but they are also presiding over organisational changes which are likely to, at the very least, undermine its role."

The RCN remains committed to the Review Body systems as an effective and fair mechanism for determining nurses pay in the United Kingdom, and has received repeated assurances from government ministers that there are no plans to remove the Review Body. However, its operation has in effect been severely constrained as a result of government policy on limiting public sector pay rises in 1983 and 1984. There are concerns from many parties that the role of the Review Body may become marginalised.

The RCN is also preparing itself for more full scale local pay bargaining, by investing in training in negotiating skills and financial analysis for local officials and stewards and by establishing computerised systems to assist in monitoring local developments in nurses' pay determination. It continues to lobby at national level to ameliorate the negative aspects of the
reforms, and is working with management in most units to establish effective ways of dealing with employee relations in the new NHS.

The RCN has remained unconvinced about the benefits to patient care of some elements of NHS reforms, but throughout the reform process has remained centre stage, acting on behalf of the nursing profession. It will continue to occupy this central position of influence as the NHS reforms are more fully implemented, by maintaining its national and local activity.

References


PART II. Les infirmières et le personnel auxiliaire dans les hôpitaux publics et privés belges par Cécile Fontaine

Introduction

La Belgique compte environ dix millions d'habitants. Entre 1933 et 1985, le pays a plus que doublé ses capacités hospitalières passant de 44.000 lits à 100.000 lits aujourd'hui. Cette évolution s'explique par deux paramètres importants, notamment le vieillissement de la population et, d'autre part, le changement de conceptions de la pratique médicale et l'introduction de technologies de pointe.

En moins d'une décennie, le personnel infirmier et soignant des hôpitaux belges a bénéficié d'une amélioration significative de ses conditions de travail et de rémunération, ainsi que d'une structuration de son activité qui contribue à reconnaître la part essentielle que joue ce personnel dans les institutions hospitalières. Un effort particulier a été accompli en matière de formation. Majoritairement féminin, le personnel infirmier et auxiliaire est concerné par les mesures d'"actions positives" proposées par le Ministère de l'emploi et du travail.

1. Personnel infirmier

Les effectifs infirmiers s'élèvent à environ 70.000 infirmières dont 43.000 infirmières graduées et 27.000 infirmières brevetées et hospitaliers. Le ratio du personnel infirmier par habitant est de 4,3 infirmières graduées pour 1.000 habitants, et en tout 7 infirmières graduées ou brevetées pour le même nombre d'habitants. Une récente étude mentionne une augmentation de 34 pour cent du nombre total du personnel hospitalier en Belgique entre 1977 et 1988. Cependant, dans l'ensemble, cette augmentation est le résultat surtout d'une forte croissance des catégories élevées (+99.5%).

Les "praticiens de l'art infirmier" sont définis dans l'Arrêté Royal n° 78 du 10 novembre 1967, relatif à l'art de guérir, à l'art infirmier et aux professions paramédicales et aux commissions médicales. La qualification d'assistante en soins hospitaliers (anciennement hospitalière) donne accès au titre de praticien de l'art infirmier, mais seules l'infirmière graduée et l'infirmière brevetée peuvent porter le titre d'infirmière. Ce rapport ne présentera pas la situation des assistantes en soins hospitaliers, minoritaires et appelées à disparaître par suppression de la qualification à ce niveau de formation.

2 Ceci explique l'emploi systématique du féminin dans ce rapport pour désigner les infirmiers et infirmières des différentes fonctions.
1.1 Evolution salariale

Une restructuration du paysage hospitalier belge a été entamée dès 1986 par le Ministre des Affaires sociales, qui a la Santé publique dans ses attributions. La réduction de la durée de séjour en hospitalisation et la fermeture de lits hospitaliers, mesures introduites, entre autres, pour faciliter les tâches du personnel hospitalier, ont eu pour conséquence une concentration des activités infirmières sur une période d’hospitalisation plus courte. La charge de travail accrue a provoqué une dégradation incontestable des conditions de vie du personnel infirmier, déjà accablé par un manque d’effectif structurel. En effet, à l’exception d’une très courte période (1981-1982), une pénurie de personnel infirmier qualifié caractérise la situation belge. La plupart des institutions fonctionnaient à cette époque de remaniement du secteur hospitalier avec des effectifs qualifiés insuffisants, parce que indisponibles sur le marché de l’emploi.

Le cercle vicieux qu’une telle situation créée (pénurie, effectifs réduits, conditions de travail difficiles, fuite du personnel qualifié, faible attractivité de la profession pour les jeunes, pénurie accrue, etc.) a provoqué la "colère des blouses blanches".

L’image positive, dont bénéficie la profession infirmière auprès de la population, sera exploitée par les organisations syndicales pour obtenir une amélioration des conditions de travail et financières de l'ensemble du personnel hospitalier: les négociations entre pouvoirs publics, représentants des gestionnaires d'hôpitaux privés et organisations syndicales aboutissent, notamment, à des augmentations de barèmes, à des congés supplémentaires, à une augmentation des primes pour les prestations de nuits et de week-ends, ainsi qu’à une révision des dotations en personnel des équipes de soins.

Le cas particulier du personnel occupé dans les services médico-techniques, dont le financement dépend des honoraires médicaux payés pour les prestations effectuées dans ces secteurs, complique les négociations. Des formules de financement spécifiques permettront au personnel employé dans ces services de bénéficier d’avantages similaires, moyennant certaines conditions (celles-ci visent à intégrer l’activité médicale et médico-technique dans la structure générale de l’institution hospitalière).

Pour étudier de manière synthétique les avantages octroyés au personnel infirmier, notons l’évolution de la part du budget hospitalier destiné à financer le personnel soignant (partie B du "prix de la journée d’entretien"). Les effets cumulés des différentes mesures qui se sont succédées entre le 1/1/1989 et le 11/1/1993 représentent un accroissement de 19,34 % pour le secteur privé, de 15,92 % pour le secteur public.

Il n’est pas question ici de détailler l’attribution des avantages octroyés. Cependant, la liste des types d’avantages démontre des approches sélectionnées pour améliorer le sort du personnel infirmier hospitalier:

5 6.000 lits aigus fermés lors de la première phase, la fermeture de 12.000 lits aigus au total est envisagée.
6 En Belgique, les hôpitaux privés sont sans but lucratif; ils sont soumis aux mêmes réglementations que les hôpitaux publics en matière de normes de fonctionnement; les conditions de leur financement diffèrent peu de celles des hôpitaux publics.
7 Le personnel des hôpitaux publics bénéficiait au départ de conditions légèrement plus avantageuses que celles qui étaient accordées dans les hôpitaux privés.
- secteur privé:
  . primes forfaitaires;
  . sursalaire pour prestations dominicales et de nuit, successivement: 20%, 30%, 35%, 40%;
  . augmentations des barèmes afférents aux fonctions d'infirmière (graduées et brevetées);
  . compléments fonctionnels pour les fonctions d'encadrement (infirmière en chef et chef de service);
  . octroi de 2 jours de congé payé supplémentaires.

- secteur public:
  . primes forfaitaires;
  . augmentation du forfait payé au personnel effectuant des prestations dominicales et de nuit: 11% du salaire brut (au lieu de 10%);
  . augmentations des salaires selon le barème;
  . compléments fonctionnels pour les fonctions d'encadrement;
  . 4 jours de congé payé supplémentaires;
  . primes horaires pour les prestations de nuit et dominicales.

1.2 Déroulement de la carrière

1.2.1 Carrière "au chevet du malade"

Une infirmière qui poursuit toute sa carrière professionnelle sans accéder à une fonction de cadre bénéficie d'une progression automatique de son salaire, par tranche annuelle ou tous les 2 ans.

Le salaire mensuel brut de base (non compris les charges patronales et les primes pour prestations dominicales et de nuit, avant imposition et prélèvement de Sécurité Sociale) est plus ou moins similaire dans les hôpitaux publics et les hôpitaux privés. Une différence favorable au privé, d'au moins 2.000 FB s'observe, avec des variations au cours de la carrière.

Le sursalaire octroyé aux infirmières effectuant des prestations nocturnes et dominicales est octroyé différemment selon les secteurs:

- à la prestation, dans le secteur privé (40% du salaire horaire brut);
- de manière forfaitaire, dans le secteur public (11% du salaire mensuel brut, quel que soit le nombre de prestations dites "inconfortables").

Les avantages et inconvénients de chaque système sont diversément appréciés selon les situations individuelles.
**Exemples de salaire mensuel brut indexé** (au 01/11/1993, en FB):

**Infirmière brevetée:**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>56 102</td>
<td>54 160</td>
</tr>
<tr>
<td>2 ans</td>
<td>60 363</td>
<td>56 126</td>
</tr>
<tr>
<td>5 ans</td>
<td>62658</td>
<td>61 371</td>
</tr>
<tr>
<td>10 ans</td>
<td>74 471</td>
<td>71 153</td>
</tr>
<tr>
<td>15 ans</td>
<td>80 488</td>
<td>78 507</td>
</tr>
</tbody>
</table>

**Infirmière graduée:**

<table>
<thead>
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<th>secteur public</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>60 800</td>
<td>58 530</td>
</tr>
<tr>
<td>2 ans</td>
<td>65 226</td>
<td>60 824</td>
</tr>
<tr>
<td>5 ans</td>
<td>69 159</td>
<td>67 217</td>
</tr>
<tr>
<td>10 ans</td>
<td>82 159</td>
<td>78 841</td>
</tr>
<tr>
<td>15 ans</td>
<td>88 176</td>
<td>86 195</td>
</tr>
</tbody>
</table>

La valorisation de l’ancienneté acquise dans une autre institution varie : certains hôpitaux en reconnaissent jusqu'à la totalité, afin d'être attractifs aux yeux du personnel qualifié expérimenté.

1.2.2 *Développement de carrière*

La hiérarchie infirmière peut compter un nombre différent de niveaux selon l'organisation interne et la taille de l'institution hospitalière.

**Hiérarchie à 3 niveaux:**

- infirmière en chef;
- infirmière chef de service (cadre intermédiaire);
- chef du département (directeur/directrice).

Ces 3 niveaux sont obligatoires.

**Hiérarchie à 5 niveaux:**

- infirmière en chef adjointe;
- infirmière en chef;
- infirmière chef de service;
- infirmière chef du département adjointe;
- chef du département.

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8 L’évolution des salaires est liée à l’évolution de l’index des prix à la consommation. Ceci a donné lieu à une augmentation de 12% entre le 01/01/1989 et le 31/12/1992; cette liaison automatique est actuellement contestée.
Le titre porté par l'infirmière responsable du département infirmier est variable. Le terme utilisé légalement est "Chef du département infirmier". En pratique, les titres de directeur ou directrice des soins infirmiers ou directeur/directrice du département infirmier sont les plus couramment employés.

Les barèmes attribués aux fonctions d'encadrement peuvent varier d'une institution à une autre, surtout dans le cas du Chef du département infirmier. La tendance observée, principalement dans les hôpitaux de grande et moyenne tailles, est l'attribution de salaires correspondants à ceux qui sont octroyés aux fonctions de direction non infirmière. Les différences peuvent être très importantes d'une institution à une autre.

Les barèmes afférents à la fonction d'infirmière en chef et de chef de service sont à peine plus élevés que ceux d'infirmière graduée. Par conséquent, le personnel d'encadrement, ne bénéficiant pas des sursalaires liés aux prestations dominicales et de nuit, obtenait un salaire inférieur à celui du personnel dont il avait la responsabilité. Pour corriger cette anomalie, des "compléments fonctionnels" ont été octroyés au personnel d'encadrement (chef et chef de service): 4% jusqu'à 17 années d'ancienneté, 6% au delà.

1.2.3 Conditions d'accès aux fonctions d'encadrement

Pour accéder aux fonctions de Chef du département infirmier et d'Infirmière chef de service, il faut être infirmière graduée/accoucheuse et avoir suivi une formation complémentaire de cadre, de licence, ou être détenteur d'un titre assimilé. Dans une majorité d'hôpitaux, la formation complémentaire de niveau universitaire est requise.

Pour devenir Infirmière en chef, il n'y a pas d'exigence légale, si ce n'est d'être infirmière graduée ou brevetée. A l'instar des hôpitaux publics, qui le demandent depuis les années 70, une ancienneté hospitalière minimale est requise (le plus souvent de 3 ans pour les graduées, de 5 ans pour les brevetées). L'exigence d'une formation complémentaire, du niveau "Ecole de cadres", se généralise. La préférence accordée aux candidats titulaires d'une Licence universitaire s'observe de plus en plus fréquemment.

1.3 Dotation en personnel

La dotation en personnel des unités de soins varie selon le type de service et d'hôpital: les lits universitaires bénéficient d'effectifs plus nombreux que les lits d'hôpitaux généraux.

Exemples de dotations:

- hôpital général:
  - service de chirurgie ou de médecine: 13 ETP/30 lits (occupation 80%);
  - service de gérontologie: 16 ETP/30 lits;
  - service de soins intensifs: 2 ETP/lit.
hôpital universitaire:

service de chirurgie ou de médecine: 17 ETP/ 30 lits (occupation 80%).

La répartition des effectifs est globalement de 3/4 d'infirmières qualifiées pour 1/4 de personnel auxiliaire. Certains services comptent jusqu'à 100% d'infirmières, majoritairement graduées.

La complexité du calcul de ces dotations en personnel est telle qu'il n'est pas utile de les détailler dans le cadre de ce rapport; d'autant que le système de financement actuel ajoute des compléments budgétaires selon le type d'activités réalisées dans les services. Ce système est en évolution constante, dans le but de répartir les moyens financiers disponibles sur base de comparaisons entre les hôpitaux, en tenant compte des besoins des patients. L'objectif est ambitieux, sa réalisation difficile...

1.3.1 Améliorations récentes

Du personnel supplémentaire a été octroyé aux unités de soins, afin de compenser les effets de la réduction de la durée de séjour et de la concentration de patients plus dépendants dans les hôpitaux.

Vu la pénurie de personnel infirmier, les responsables politiques souhaitaient former du personnel auxiliaire de façon accélérée, et les incorporer dans les équipes pour leur confier certains soins aux patients. Les organisations professionnelles infirmières se sont opposées à ce projet, car elles y voyaient un risque majeur de déqualification professionnelle globale et de diminution de la qualité des soins prodigués aux patients.

Une alternative a été proposée: vu le nombre croissant de tâches administratives et la charge représentée par le transport des patients hospitalisés vers les divers services médico-techniques, l'aide de personnel auxiliaire chargé de ces fonctions a été sollicitée. Le financement d'aides administratives et logistiques et d'auxiliaires pour le transport interne des patients a été ajouté au budget des hôpitaux, depuis janvier 1992 (cfr. pp. 8 et 9).

1.4 Structuration du département infirmier


Le Chef du département infirmier est sous la dépendance directe du directeur, responsable devant le gestionnaire; sa position est au même niveau que le médecin en chef et que les chefs des services techniques et financiers.

Un chapitre IV, qui prévoit la structuration de l'activité infirmière, est inséré dans la loi sur les hôpitaux. Dans chaque hôpital, il faut un Chef du département infirmier, responsable de l'organisation et de la coordination des soins infirmiers et de la gestion journalière du personnel infirmier et soignant dans l'ensemble de l'établissement en ce qui concerne l'exercice de l'art infirmier.
Les infirmières chefs de service, qui composent le cadre intermédiaire, assistent le chef du département infirmier. Ils sont soit responsables de plusieurs unités de soins ou de services médico-techniques, soit de fonctions spécifiques, obligatoires, telles la formation permanente et l’hygiène hospitalière. Une infirmière chef de service au moins doit être prévue par 150 lits.

Le cadre infirmier comprend l’ensemble des infirmières en chef et, le cas échéant, les infirmières en chef adjointes. Le département infirmier est composé du personnel infirmier et soignant. Le personnel soignant est défini comme suit:

"...tous les membres du personnel qui ne sont ni médecins, ni accoucheuses, ni praticien de l’art infirmier, ni praticien d’une profession paramédicale ... (définis dans l’Arrêté Royal n° 78 du 10/11/1978), mais qui assistent le personnel infirmier lors de l’administration des soins aux patients".

"L’activité infirmière doit être organisée de manière à faire partie intégrante de l’activité hospitalière, étant entendu que l’organisation de l’hôpital doit être telle que l’activité infirmière puisse s’y déployer dans des conditions optimales" (article 17 ter, paragr. 1er - Loi sur les hôpitaux).

1.4.1 Formation permanente

La formation continue du personnel infirmier est obligatoire depuis janvier 1986: une "stratégie" de formation permanente doit être prévue pour chaque infirmière (A.R. du 14/08/87). Le financement en est prévu depuis 1991: le montant initialement prévu, lié au nombre de lits que compte chaque hôpital, a été remplacé par une somme forfaitaire annuelle de 900 000 FB.

2. Personnel auxiliaire

2.1 Position hiérarchique

Quelles que soient sa qualification et sa fonction, directement liées aux soins ou non, le personnel auxiliaire du département infirmier travaille sous la responsabilité des praticiens de l’art infirmier.

L’Arrêt Royal du 14/08/1987 rend la permanence infirmière graduée ou brevetée obligatoire, par 30 patients hospitalisés. Dans les faits, cette disposition exige la présence constante, c’est-à-dire 24 heures sur 24, dans chaque unité de soins, d’au moins une infirmière graduée ou brevetée. Le personnel auxiliaire n’est donc plus autorisé à assumer seul la surveillance des patients.

2.1.1 Reconnaissance des droits acquis

Les réglementations successives limitent de plus en plus strictement les tâches et responsabilités du personnel soignant. La publication, le 18 juin 1985, de la "liste des actes techniques de soins infirmiers et des actes médicaux pouvant être confiés par un médecin, ...", interdit ces prestations aux non-praticiens de l’art infirmier. Les personnes qui peuvent
se prévaloir d'avoir pratiqué une ou plusieurs de ces prestations, pendant au moins 3 années avant le 01/01/1986, peuvent obtenir l'autorisation de continuer à les pratiquer. Dans ce sens, on parle de "reconnaissance des droits acquis".

Ces personnes ne peuvent plus apprendre de nouvelles prestations relevant de l'art infirmier ou de guérir; elles ne bénéficient d'aucune assimilation à un titre; elles ne peuvent prétendre bénéficier d'une valorisation selon le barème.

Le personnel soignant qualifié est, pour l'essentiel, composé d'aides sanitaires et de puéricultrices. Sa formation est du niveau professionnel secondaire supérieur. Les autres auxiliaires soignants, de moindre qualification, disparaissent progressivement du secteur hospitalier.

2.2 Evolution salariale

Les barèmes les plus fréquemment octroyés aux puéricultrices et aux aides sanitaires sont de deux niveaux: les échelles des barèmes 1.22 et 1.35, du secteur public, salaire mensuel brut (en FB):

<table>
<thead>
<tr>
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<th>barème 1.22</th>
<th>barème 1.35</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
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<td></td>
</tr>
<tr>
<td>2 ans</td>
<td>52 835</td>
<td></td>
</tr>
<tr>
<td>5 ans</td>
<td>57 788</td>
<td></td>
</tr>
<tr>
<td>10 ans</td>
<td>60 365</td>
<td></td>
</tr>
<tr>
<td>15 ans</td>
<td>64 759</td>
<td></td>
</tr>
</tbody>
</table>

A la différence du personnel infirmier, il n'est pas prévu de dérogations aux règles qui limitent la valorisation acquise dans une autre institution ou un autre secteur, le personnel auxiliaire étant en nombre plus que suffisant sur le marché de l'emploi.

Les avantages accordés depuis le 1/1/1989 ont, de manière générale, été accordés au personnel auxiliaire comme aux infirmières.

2.3 Auxiliaires non soignants

En Belgique comme dans d'autres pays européens et occidentaux, le nombre de personnes sans emploi est en progression constante. La majorité d'entre elles sont des femmes, ne disposant d'aucune qualification et/ou d'un très faible niveau de formation.

Confrontés à cette augmentation de demandeurs d'emplois, d'une part, et aux revendications d'amélioration des conditions de travail du personnel infirmier et soignant, d'autre part, les responsables politiques sont tentés de confier des soins à du personnel non qualifié ou rapidement formé. Cette formule présente le double avantage de procurer un emploi, qui plus est, peu rémunéré, donc pesant peu sur les budgets de financement des hôpitaux, à du personnel qui n'a par ailleurs presque aucune possibilité de s'intégrer dans le marché du travail.
La réaction des organisations professionnelles infirmières et des directions de département infirmier a réorienté les propositions (voir chapitre 2 de ce rapport). Deux nouvelles catégories de personnel ont ainsi fait leur apparition officielle dans les hôpitaux belges: les aides administratives et logistiques et les auxiliaires affectés au transport interne des patients.

Les tâches administratives liées aux soins sont en augmentation et alourdissent les responsabilités du personnel infirmier; rangement, réapprovisionnement en matériel courant détournent un temps précieux des soins directs aux patients. Confier ces activités à des aides administratives et logistiques représente un réel soulagement pour le personnel soignant, qui montre habituellement peu de dispositions pour ce type de travail.

Cette option présente donc de multiples avantages, car elle vise à alléger la tâche du personnel infirmier et soignant tout en lui réservant des activités qui réclament sa qualification. De même, elle offre le réel potentiel de créer des emplois de personnel disposant d'une formation limitée, qui peut se compléter en cours d'emploi. Quant à ces emplois, ils sont valorisants, car appréciés tant par les soignants, soulagés d'astreintes administratives et pratiques, que par les patients, globalement mieux servis.

Le financement d'aides administratives et logistiques est prévu depuis 1992, à raison d'un 1/2 ETP par 30 lits (médecine, chirurgie, réanimation).

Le transport interne des patients de l'Unité de soins vers les divers services médico-techniques (radiologie, bloc opératoire, polyclinique et autres) est également en croissance, puisque ces examens et techniques spéciales se concentrent durant un séjour hospitalier de plus en plus réduit.

Des auxiliaires affectés au brancardage interne sont également financés depuis 1991, à raison d'un 3/4 temps par 30 lits de services tels chirurgie ou médecine, par exemple. Ces emplois, requérant davantage de qualités humaines et de bon sens qu'une qualification réelle, contribuent également à améliorer les conditions de travail du personnel soignant, tout en améliorant le service rendu aux patients hospitalisés.

Des centaines d'emplois ont ainsi été créés, avec un impact financier limité pour le budget de la Sécurité sociale: il y a eu en effet glissement d'une charge du secteur chômage vers le secteur de santé, la différence entre le montant de l'indemnité de chômage et celui du salaire octroyé à ces aides étant modérée.

2.4 Mesures d'encouragement à la formation

Dans le but de diminuer le problème de la pénurie de personnel infirmier qualifié tout en offrant des perspectives d'emplois à des personnes peu qualifiées, les pouvoirs publics belges ont mis en place des mesures d'encouragement spécifiques pour certaines catégories de personnes désireuses d'entamer des études d'infirmière.

Les chômeurs indemnisés peuvent continuer à bénéficier de leurs allocations de chômage tout en suivant une formation individuelle pour l'obtention d'une qualification d'infirmière (graduée ou brevetée), pour autant qu'ils soient chômeurs et demandeurs d'emploi depuis au
moins un an et que la formation s’inscrive dans le cadre d’un plan d’accompagnement. Un contrat de formation est établi entre l’établissement de formation et le FOREM (Office Communautaire et Régional de la Formation professionnelle et de l’Emploi).

Outre le maintien de ses indemnités de chômage, le stagiaire en formation bénéficie d’une prime horaire (40 FB en 1993) et du remboursement de ses frais de déplacement.

Le Fonds Social des Hôpitaux Privés gère les moyens financiers provenant d’une cotisation patronale (0,25 % de la masse salariale) en faveur d’initiatives en matière d’emploi et de formation. Les bénéficiaires privilégiés de ces aides sont des personnes appartenant à des "groupes à risques". Auparavant définis par la loi, ces groupes à risques sont actuellement déterminés par les Commissions paritaires du secteur des soins de santé. Les groupes à risques sont, notamment: les chômeurs de longue durée, à qualification réduite et les travailleurs touchés par un licenciement collectif.

Sont également visées les personnes qui réintègrent le marché de l’emploi après une période de plus de trois ans. Dans la plupart des cas, il s’agit de femmes, ayant quitté leur emploi pour s’occuper de leurs enfants, et qui souhaitent se réinsérer dans la vie professionnelle. A ce jour, 398 personnes, dont 50 hommes, ont bénéficié des avantages offerts par ce Fonds Social.

Le groupe des femmes souhaitant reprendre le travail après une interruption de plusieurs années, appelées les "femmes rentrantes", est également composé d’infirmières, qui hésitent ou éprouvent des difficultés à reprendre des activités professionnelles. Elles ne peuvent à proprement parler être classées dans la catégorie des personnes non qualifiées, mais leur situation est assez identique.

Certaines organisations professionnelles et hospitalières offrent des programmes spécifiques de formation, dont l’objectif est une remise à niveau professionnelle. Ceci comprend l’adaptation à l’évolution technique médicale, la mise à jour des connaissances en soins infirmiers, et la préparation psychologique à la réintégration dans une équipe de travail.

3. **Égalité des chances**

3.1 **Programme national d’actions positives**

La notion d’action positive n’est pas nouvelle en Belgique. Une politique active d’égalité des chances entre hommes et femmes est menée par le gouvernement depuis 6 ans. Après une phase pilote, au cours de laquelle une large campagne de sensibilisation a été menée auprès des organisations syndicales, des représentants patronaux et des entreprises, un cadre légal a été défini.

Les "actions positives" sont un instrument politique au niveau de l’organisation du travail, dans le but de lever des inégalités de fait entre hommes et femmes. La loi du 14 août 1978 impose le principe de l’égalité de traitement entre hommes et femmes en ce qui concerne les conditions de travail, l’accès à l’emploi, à la formation professionnelle et aux possibilités de promotion. Mais en fait, les chômeuses sont plus nombreuses que les chômeurs, les femmes occupent surtout les fonctions subalternes, offrant peu de sécurité.
d'emploi et de possibilités de promotion et les fonctions dirigeantes sont quasi exclusivement dévolues aux hommes.

3.1.1 Secteur privé

L'Arrêté Royal du 14 juillet 1987 concerne le secteur privé et donne une définition du "plan d'Egalité des chances" que peut volontairement établir une entreprise.

Les "actions positives" sont considérées comme matière de négociation entre partenaires sociaux depuis l'Accord interprofessionnel de 1989-1990; elles figurent parmi l'ensemble des conditions de travail négociées entre employeurs et travailleurs. Une Cellule d'accompagnement, créée en 1989 dans le service des Relations Collectives de Travail du Ministère de l'Emploi et du Travail, conseille les secteurs et entreprises individuelles.

L'Arrêté Royal du 12 août 1993 impose à toutes les entreprises un rapport annuel sur la situation de l'égalité des chances entre hommes et femmes.

Les projets d'"actions positives" peuvent être financés par le Fonds national pour l'emploi ou par les Fonds sectoriels (cotisation de 0,25 % de la masse salariale des entreprises) ou le Fonds social européen, par le biais de différents programmes.

3.1.2 Secteur public

L'Arrêté Royal du 27 février 1990 prévoit des mesures visant la promotion de l'égalité des chances dans les services publics. Un rapport est établi chaque année sur l'état d'avancement de la mise en œuvre de cet Arrêté. Il en ressort que de nombreuses administrations mènent des actions dans leurs services (jury d'examen équilibrés, formations en faveur des femmes, initiatives en matière d'accueil d'enfants, etc.).

3.2 Concrétisation dans les hôpitaux

Le secteur non marchand a fait l'objet d'un intérêt particulier dans le cadre de l'égalité des chances.


Les mesures prises sont de 5 types:

(a) formations de type court:

- pré-formations pour les personnes qui n'ont plus exercé depuis longtemps;
- formations pour personnes sous-qualifiées (personnel d'entretien, aides soignantes, aides administratives et brancardier(e)s);

(b) enseignement infirmier pour adultes et pour des groupes à risque, principalement des femmes et des jeunes filles; ce projet exige, pour être mené à bien, des aides
financières, des congés-éducation et le soutien de l’encadrement, et il est opérationnel depuis janvier 1993 (cfr. supra, chapitre 2.4);

(c) enquête relative au manque d’infirmières, menée par le Research Instituut voor Arbeid en Tewerkstelling et l’Institut Wallon d’Etudes, de Recherche et de Formation;

(d) projet de fin de carrière, visant à proposer de nouvelles tâches aux plus de 55 ans, de façon à leur garantir une sécurité d’emploi;

(e) optimalisation des structures d’accueil d’enfants en fonction des besoins du personnel des institutions de soins de santé (prévision de création de 55 emplois équivalents temps plein).

Elles sont toutes financées via la cotisation de 0,25 % de la masse salariale, en faveur des groupes à risques.

Une formation est offerte aux personnes de contact des institutions participantes. Cette formation, d’une durée de 5 jours, se base sur l’analyse du comportement des personnes pour politique d’emploi et de carrière plus axée sur la personne. Une action de formation est également menée à l’égard des représentants syndicaux (3 jours de sensibilisation).

Les hôpitaux publics bénéficieront dans le courant de l’année 1994 d’une action de formation similaire. Ces mesures favorables aux femmes ne peuvent néanmoins occulter une réalité qui l’est moins: si le personnel infirmier et soignant est majoritairement féminin, il faut constater que l’encadrement compte une proportion à peu près inverse d’éléments masculins.

Aucune statistique récente ne permet de déterminer le rapport hommes/femmes parmi les cadres infirmiers, mais l’observation simple permet d’affirmer que, dans ce secteur comme dans les autres, le personnel d’exécution est majoritairement féminin alors que les chefs, surtout les cadres supérieurs, sont essentiellement masculins.

4. Conclusion

Les restructurations du secteur hospitalier belge ont affecté les conditions de travail du personnel infirmier et soignant. Si la pénurie de personnel infirmier limite les possibilités d’accroître les effectifs qualifiés en Art infirmier, le recours à du personnel auxiliaire, chargé de tâches administratives et logistiques ainsi que du transport interne des patients, a néanmoins permis d’en atténuer les effets négatifs. Diverses mesures prises depuis janvier 1989, telles que des augmentations salariales et des congés supplémentaires, ont amélioré la situation du personnel hospitalier et des infirmières en particulier.

La structuration du Département Infirmier, de son encadrement et de sa position hiérarchique, l’obligation et le financement de la formation permanente, contribuent à l’amélioration du statut du personnel infirmier dans la structure hospitalière.
Majoritairement féminin, le personnel hospitalier bénéficie des mesures générales prises en faveur de l'égalité des chances entre hommes et femmes, à l'initiative du Ministère de l'Emploi et du Travail (les "actions positives"); des programmes spécifiques sont également centrés sur le personnel auxiliaire.

L'évolution des services de santé conduit à poursuivre la diminution du nombre de lits et du nombre d'hôpitaux et à des restrictions des budgets qui leur sont accordés, qui augurent mal d'une amélioration des conditions de travail dans ces structures de soins: le personnel soignant et infirmier, malgré l'opinion généralement favorable dont il bénéficie auprès des pouvoirs publics et de la population, ne peut se reposer sur les acquis, s'il veut éviter de les voir se dégrader au fil des restructurations et adaptations des secteurs de santé.
PART III. The Future of the Nursing Profession: Rethinking Health Care Work in North America by Sholom Glouberman

Introduction

"Care, cure, control and community" are terms applied to different actors on the health care stage. Henry Mintzberg and I have been working on a framework to understand hospitals and other health care organizations. In it, we describe these actors, some of their major characteristics and how they get along with each other. We have used this framework to diagnose the problems of, and to suggest solutions for, hospitals and other health care organizations in North America and Britain. In this paper, I will present our framework, identify major trends in health care and then consider some possible directions for nursing.

1. The Four Faces of Health Care

Most health care organizations contain the groups in figure 1 (see below). Doctors' main role is to direct the cure of patients while nurses and other health care professionals are primarily dedicated to their care. Both groups work and manage clinically - close to patients. They work down because they are at the clinical edge of the organization. The horizontal cleavage in the figure separates down from up. Managers who control the allocation of resources, and board members who represent the community are up. These two groups manage and work up and away from direct patient contact. A vertical cleavage separates care and control (nurses and managers) who work and manage in the hospital, from cure and community (doctors and board members) who are usually not hospital employees, and who, though loyal to the hospital, have other and more fundamental attachments out of it.

The contention is that in dysfunctional health care organizations there are powerful divisions among the four groups. Each forms a fiercely independent enclave that does not understand, cooperate or even talk to the others. This complicates the operation of hospitals and other health care organizations, and contributes to crises in health care delivery. The four faces of health care inhabit the same institution in much the same way as different personalities may inhabit a single individual with a multiple personality disorder as in The Three Faces of Eve. I will begin with a brief characterization of the four faces in hospitals.

1.1 Cure

Doctors are in the down and out quadrant of the framework although they are hardly down-and-out. According to recent OECD studies, doctors tend to earn within a narrow band of net income (Sandier, 1990). In most Western countries, their average income is a multiple of the national average wage, and their income rises with the per capita GDP of the country they work in. The net earnings of GPs are in a narrow band of between two and three times

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the national average wage. The method of remuneration does not seem to have much impact on their net income. This may be because doctors typically live to an upper middle class lifestyle in almost all western countries.

Hospital doctors tend to have a highly specific interest in a specialized (or even sub-specialized) area of cure usually defined by body parts, organs or diseases. They try to know as much as they can about this area, to find patients for whom they can apply this knowledge with increasing proficiency and from whom they can learn even more. National and international colleagues in their area form a kind of "chimney" of specialization that they climb to gain clinical, academic and research recognition [Freddi, 1989]. If they do relate to a career type, it is that of independent professional practice. They tend to remain in the same job for their entire work lives. Their efforts are to expand their practice, which usually includes clinical work.

Perhaps because of their professional autonomy and the demands of their life style, they may see the hospital as a location in which they do their work, not as an organization they work for. They often behave like independent entrepreneurs and have been compared to shopkeepers who work in a town, not for it. Though loyal citizens of the town, their interests are not always identical with those of other residents in it. [Shopkeepers might prefer a larger shopper's parking lot to a swimming pool, for example.]

1.2 Control

Control is very difficult for non-clinical health care managers. Because they are far from patients and do not have clinical expertise they tend to manage away from the clinical activities. Managers are up and away from patients in several ways.

They manage operational activities that do not directly involve patient care. Middle managers often spend 85% of their time on such services as food preparation, housekeeping and parking, though these items consume only 15% of hospital budgets.

Very senior managers manage up to external agencies to assure the funding of their hospital and to improve its ties to academic and research institutions. They feel their role is to manage strategically not operationally and they stay far from patients.

Health care managers prefer to see their institutions as corporations, and themselves as corporate employees. Most have come to their present posts after a series of jobs, usually in different hospitals. Their career paths are spirals in which they move laterally and upward between five and seven jobs, each with a more prestigious title, a bigger budget, or a larger work force until they become CEOs.

When they join an institution, they are in. As employees they feel an obligation to their organization and at times do not understand why doctors and other professionals do not behave more corporately. A major objective of hospital managers is to have a well managed, forward looking corporation. This is hard to do because they have little authority over clinical activities. They open or close beds, and allocate or withdraw resources in similarly crude and ineffective ways.
1.3 Community

The community is represented by boards and their members. Boards are the final authority of hospitals and their members have special responsibility to oversee its activities. In health care organizations, boards are farthest from the day to day activity of the hospital. As non-professionals, they do not understand much about the clinical activities, and because of their distance they cannot appreciate many operational problems.

Traditional boards contained prominent members of the community who donated their time and money to hospitals as social institutions. The social importance of the institution reflected on them. They considered "their" hospitals to be the "best" because of an area of excellence, a historical bit of pioneering medicine, the presence of international figures, etc.

Board members continue to have a strong obligation to maintain the reputation of their institution as "the best" and if there were a universal motto for board members it very well might be "Access to the Best". In the past board members went to great lengths to follow this motto and put their money where their mottos were. Today the costs of health care and the introduction of government and insurance funding, leave them able to contribute only at the margins. They might build a building, or buy a piece of expensive equipment, but they cannot support the operational costs of hospitals.

Financial constraint has led boards to focus on a second goal: keeping to the budget. The demands of fiscal responsibility put boards into a dilemma: they are caught between excellence of cure and control of expenditure. In many health care organizations the new motto (with dismay) is "Access to the best that is affordable".

The meeting is the venue of board members. Their organizational structure is the committee, of which there are many in most hospitals. Their career path (or perhaps, fate) is to move from committee to committee and some serve on many councils, boards, trusts, and task forces during their careers.

1.4 Care

Although the caring face of health care includes nurses and other allied health workers, I will concentrate on nursing in this paper. Nurses' main responsibility is for direct and continuous patients care. They are closest to the patients and organize and manage the work flow around them.

Nurses point out that historically they were first to run hospitals. When nurses were in charge, they had responsibility for all patient care and summoned doctors only when medical interventions were necessary. Managers are comparative parvenus to health care organizations although they now carry considerable authority.

From the time of Florence Nightingale, nursing had a military organization - it was a pyramidal hierarchy with a split between the noncommissioned troops and the commissioned officers. Nurses above a certain level were officers. Student nurses, staff nurses, and most ward sisters and head nurses were the non-commissioned troops. In the early days senior nurses, like military officers, had upper class backgrounds. Later academic credentials
became the path to senior rank and the distinction continues. Some nurses argue that only the senior nurses are professionals because they are the only ones with appropriate academic credentials and enough professional authority [White, 1985]. Nonetheless all nurses have a strong loyalty to their profession.

In hierarchical organizations the career path is up or out. Thus nurses' career moves tend to be up the hierarchy or out of nursing. For younger nurses a tendency has been to move out of nursing, and then in and out as economic and family demands change [Audit Commission, 1991].

The nursing literature describes the struggle between doctors and nurses. This has been called the Doctor-Nurse Game. The journals of two medical residents "...written more than 100 years apart...revealed more similarities than differences in nurse-doctor relationships" [Pillitteri, 1993]. A book on the history of nursing summarizes:

"For the last Hundred years the general hospital has been the key battleground for the various forces arrayed in the division of labour in health care. There seems no reason this should change now." [Dingwall, 1988]

This military language describes the doctor-nurse struggle as a war of the sexes about careers, organizations, professional status and income, authority over patients, and even models of patient care [Clifford, 1989].

1.5 Summary

Figure 1 summarizes the characteristics of the four faces of health care. Each works to a different organizational type, has different interests and a different career path. They are even differences in the language they use. Managers adopt the most recent terms from the Harvard Business Review. Nurses speak of care plans, tasks and standards of practice. Doctors use Latin words for common organs and diseases. Board members insist on plain talk but seem never to get it.

It is easy to find metaphors for the faces. For doctors there is the scalpel which best represents the interventional nature of their activity and the inclination to cut up everyone who opposes them. The managers are the axe to brutally chop resources in times of crisis. Board members are like gavels. They make loud noises at meetings, but have no real power outside them. For nurses the choice is difficult. Are they the hands of health care who hold everything together, or the needle which pricks the pretensions of the doctors, or cotton batting to quiet things down? The strong differences between the faces, result in misunderstandings, miscommunications between them and have a large role to play in the dysfunctional nature of many health care organisations.
Figure 1: Characteristics of Four Faces of Health Care

<table>
<thead>
<tr>
<th></th>
<th>Doctors</th>
<th>Nurses</th>
<th>Managers</th>
<th>Boards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career Path</td>
<td>Steady state</td>
<td>Linear</td>
<td>Spiral</td>
<td>Transitory</td>
</tr>
<tr>
<td>Career Movement</td>
<td>None (Growth)</td>
<td>Up and/or out</td>
<td>Lateral &amp; upward</td>
<td>Lateral/up</td>
</tr>
<tr>
<td>Jobs in Career</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>Many</td>
</tr>
<tr>
<td>Status Symbols</td>
<td>Beds</td>
<td>Span of control</td>
<td>Title, budget span of control</td>
<td>Role in real world</td>
</tr>
<tr>
<td>Organizing Structure</td>
<td>Prof. practice</td>
<td>Peace time army</td>
<td>Corporation</td>
<td>Committee</td>
</tr>
<tr>
<td>Value Base</td>
<td>Proficiency</td>
<td>Professional</td>
<td>Efficiency</td>
<td>Access to the Best</td>
</tr>
<tr>
<td>Currency</td>
<td>Time</td>
<td>Staff and Hours</td>
<td>Money</td>
<td>Money Quality</td>
</tr>
<tr>
<td>Job Security</td>
<td>Tenure</td>
<td>Job Market</td>
<td>Contractual</td>
<td>Time Limited</td>
</tr>
<tr>
<td>Metaphor</td>
<td>Scalpel</td>
<td>Cotton wool</td>
<td>Axe</td>
<td>Gavel</td>
</tr>
<tr>
<td>Work Activity</td>
<td>Cutting Medicating Talking</td>
<td>Touching Medicating Talking</td>
<td>Talking</td>
<td>Talking</td>
</tr>
</tbody>
</table>
1.6 The Four Faces at Large

The discussion so far has focused on the hospital, the scene of acute care. We can bump up our framework to a more general level to represent health systems. Thus, as shown in the above Figure 1, the four faces of care, cure, control and community remain, but each quadrant contains the corresponding system level organizations. Though the faces are different, the relationships and dynamics seem remarkably similar.

Cure becomes the general hospital, which, in a way similar to the doctors within the hospital, delivers its service directly to the public. It usually receives the most resources. The expenditure of those resources can result from its internal interests and priorities, unrelated to other health care providers.

Control on behalf of the public is exercised by administrative agencies rather than individual managers. In most Western countries, these take the form of the state department of health (as in the Canadian provinces that administer Medicare), or a separate government agency (as in the National Health System of England). Otherwise, as in the United States, independent agencies, such as insurance companies, try to play this role.

The community at large is once more up and out. Community representatives - health care politicians, lobby groups, and boards of the various agencies - tend to be more aggressive at this level. Often they have no direct knowledge of health care and an outsider's desire to gain political leverage or avoid scandal.

Care takes the form of the plethora of individuals and institutions outside general hospitals, who concern themselves with the general health of the population (sometimes under the broad label of "community care"). These include, for example, general practitioners of medicine, long-term mental and geriatric hospitals, and the array of so-called "alternate" health services beside formal medicine, such as chiropractic, midwifery, naturopathy, and acupuncture.

2. Fragmentation

The cleavages among the four faces are exacerbated by further fragmentation in the world of health care and inside each face. Some readers of the paper have suggested that although the framework contains four faces of health care, there are, in fact, many more. For the sake of convenience all the allied health professionals and technologists are included with nurses. As nursing functions have become more specialized, physiotherapists, occupational therapists, social workers, and a range of specialized technicians like phlebotomists, respiratory technicians distinguished themselves from nurses. They developed their own practice standards and some have established their own professional bodies. Similarly non-clinical support staff are included with managers although there are differences between them.
2.1 Cure

More knowledge in narrower areas has spawned four times as many certified specialties and sub-specialties as forty years ago [Swanson, 1993]. There have been great benefits from the knowledge base of medical science as new and more effective interventions appear. But there has also been a widely acknowledged cost of fragmentation. Specialists tend to work in their own chimneys and crossover between them is hard at times.

The recent case of the death of a Boston Celtics basketball player illustrates this very well. Reggie Lewis was a star player for the Boston Celtics. After he collapsed during a playoff game, he was examined by two sets of doctors in two different Harvard Teaching hospitals. One group diagnosed his problem as a serious heart condition and another said he had a slight neurological problem but an athlete's heart [Globe and Mail, 1993]. He collapsed again and died several months later.

2.2 Control

The British Audit Commission recently revealed dramatic consequences of management fragmentation [London Times, 1993]. They found that it takes six people and seventeen different operations to change a light bulb in an NHS hospital. This bureaucratization of procedures has led to a fragmentation of functional roles and tasks. There are many forms to fill out, lots of delay, poor communications between departments even though everyone might be trying very hard. The manager of electricians in a hospital worked hard to improve the light bulb changing and reduced it to a week in non-urgent cases.

2.3 Community

Fragmentation extends into governance. Boards have very many committees with separate and often redundant mandates. They create even more sub-committees and task forces to deal with specific issues or undertake new projects. One hospital had a committee of committees simply to keep track of other committees.

2.4 Care

In nursing, many specialties follow medical disciplines. Operating room nurses distinguish themselves from those in intensive care areas; emergency room nurses consider themselves superior to staff nurses in the medical wards. The head nurse of dialysis in one hospital distinguished between haemodialysis nurses and peritoneal dialysis nurses by saying that each job requires a different personality, background and training.

The reduction of nursing work into fragmented tasks is more serious. Workload measurement connected to information systems has redefined patient care as the sum of services provided [Hart, 1991]. This has created a serious dilemma for nursing. As nursing work became redescribed as tasks, technicians or other professionals such as blood drawers and psychological counsellors undertook much of the technical care. Aides and other non-professionals dressed or fed patients and did the more hands on tasks. There was little direct patient care exclusive to professional nurses, and for some it is hard to see what remains essential to the nursing profession [White, 1985; Hugman, 1991; Jolley, 1993].
A harsh separation between academic training and the reality of the work they face in the wards has made for a difficult transition for new nurses. Most are not ready for what faces them and many leave nursing because they cannot reconcile the academic nursing theory with practice. The demands of academic nursing for careful assessment and planning of care are distant from the painful and difficult work of caring for patients [Hingley, 1986].

The farther away a program gets from an apprenticeship system, and the more an educational program attempts to prepare nurses who can deal effectively with the knowledge and technological explosions now and in the future, the greater will be the likelihood of producing school-work conflict and reality shock [Kramer, 1974].

2.5 Summary

Inside hospitals the fragmentation of health care makes it harder to manage workflow. It results in redundant or contradictory diagnoses by medical specialists, nurses, physiotherapists and social workers. They all have their models of care, their standards of practice, and their own professions to defend.

The multiplicity of fragmented roles results in a grid with hundreds of job categories each with many levels. Many cells contain only one incumbent. The division of tasks means that in a three-day stay a patient will have face to face contact with between 50 and 80 people. Handovers from shift to shift, from professional to professional, and from professional to support worker are invariably difficult. They require large amounts of paperwork, carry with them an inefficiency of handover and increase the risk of error.

Nurses especially suffer in this environment. It is difficult to coordinate extremely complex processes with so many authorities, ideas and demands. They find themselves caught between the mountains of paperwork and the needs of patients.

At the system level the fragmentation of institutions and organizations results in duplication of services and rigid boundaries between them that makes patient flows difficult and cumbersome between different levels of care and between different institutions at the same level. The relationship between institutions is often fraught with power politics and envy. The burden of discharge and transfer frequently falls on nursing which is put into an impossible position, caught between the demands of care and those of efficient use of institutional beds.

Similarly policy makers and regulators find themselves caught between the urgent demands of acute care organizations and the recognition that the needs of community are rarely met. Often well thought out policies seem to have no effect on these disparities of allocation.

3. Attempts to Change the Organization of Health Care

There have been many attempts to change the organization of healthcare. Most recognize the splits between care, cure, control and community. Some try to force them to conform to external standards, others demand that they merge their personalities. Yet others have a fundamental trust in the rationality of responses to management information systems.
It is beyond the scope of this paper to review these attempts in detail. They have had mixed results as the examples below suggest.

The introduction of care planning in nurses has helped nurses in some hospitals to coordinate workflow while in others it has increased paperwork at the expense of direct care for patients. The development of clinical directorates has given some doctors management responsibility and brought them into the organization. For others it has been a painful experience that merely proved their incompetence at management and the unwillingness of managers to give up control. The use of sophisticated management information systems has helped managers to identify some problem areas, but frequently they do not answer questions raised by the current crisis. Strategic planning has helped some health care organizations and their boards to identify issues and prepare future directions. In others it has been a meaningless exercise that produces an unimplemented and unread document. When these attempts succeed it may be due to a reduction of the boundaries between the faces. When one face imposes solutions on the others in a continuing struggle for dominance, they tend to fail.

4. Three Directions

Three possible directions for health care and their implications for nursing professionals can be considered:

(a) present trends continue;
(b) there is a massive shift toward community and primary care;
(c) there is a dramatic rethinking of how health care work is done.

The three possibilities are analyzed in more detail below.

4.1 Present Trends Continue

If present trends continue, most new health policy will not succeed in changing the current patterns of control and authority in health care delivery. But the funding for health care will be a continuing and increasing problem. New technological innovations will demand more resources. There will be even more political pressure on health care. Further attempts to "fix" the hospital will not succeed because the competing professional groups and institutions will continue to maintain their boundaries. Health care costs will continue to spiral out of control and outcomes will become even more mixed than they are now.

4.1.1 Community

Government and other outside forces respond to health care crises by redesigning their health care systems. Usually this affects hospital boards. In the UK, the government recently created independent hospital trusts with their own boards. Simultaneously several Canadian provincial governments eliminated boards from their hospitals. Both sets of changes come from a concern to provide a stronger community face in institutions. These
externally imposed changes to the governance of health care organizations will doubtless continue but their effect on health care delivery is less clear.

4.1.2 Control

The management of health care organizations is already in frequent crisis. If present trends continue, these crises will increase in frequency and severity. The constant response to crisis is reorganization. Health care managers have become more expert at changing them than running them. Their effectiveness is questionable. A recent study published by the University of Toronto Hospital Management Research Unit suggests that the differences between financially distressed hospitals and ones that are financially sound has little to do with manageable variables. Indeed some managers feel they are pulling levers unconnected to anything at all.

4.1.3 Cure

Of all the faces doctors are most under attack. Dissatisfied patients sue them; financially strapped governments and insurance companies squeeze their income; media identify them as villains of the health care crisis along with drug companies. Some doctors are leaving their practices because of the high cost of insurance, others are sensitive to growing patient mistrust. The traditional response of the profession has been to fortify its enclave, strengthen the boundaries and fight off all attacks.

4.1.4 Care

As nurses increase their professional status in hospitals, and lift the level of academic credentials, their services become more expensive. Financial pressures on hospitals force them to hire fewer nurses. Technicians and nursing aides (sometimes called "nurse extenders") assume more responsibility for patient contact. If these trends continue, a small core of professional nurses will become brokers for caring services and managers of nurse extenders who will do the hands on care of patients.

Nursing careers will then become more professionalized but will be farther from the caring role that has been the tradition of nursing. Some nurses see this as an appropriate future for nursing, while others argue that this would merely formalize the split between the troops and the officers that has been the tradition of nursing. The "real" nurses are and always have been "pink collar" workers who are not really professionals at all.

If pressures of professionalism will drive some highly credentialed nurses into a brokerage role, it will cause others to become "doctor extenders." There will be fewer junior doctors in most hospitals and the attending staff does not wish to fill this role. Professional nurses have begun to perform their duties. This forces them to do less caring and more intervention with patients as the price for greater professional status.

4.2 More Community and Primary Care

There have been many attempts to shift resources from acute and long term care institutions to primary and preventive care and care in the community. There are three strands to these movements two of which create new possibilities for nursing.
The first and most effective was the effort to close the large ex-urban psychiatric asylums and bring long term care for mental patients back to the community. The effects of this change have already been felt throughout health care. Improved medication and the rising cost of care contributed to this trend as did those professionals who considered the large hospitals to be inhumane. They argued for the release of mental patients into the community and for treatment closer to home. Long term care reforms which began in psychiatric hospitals have been extended to other long term care areas such as physical and mental disability and to care of the elderly. There has been far less success in shifting the resources from long term care facilities into well functioning community based services.

The second is the organization of healthy cities and communities. In many countries the healthy communities movement recognizes that health care is only a small contributor to the health of the population compared to jobs, housing and education. Proponents urge that policies to promote the health of the population must be "demedicalized" and that control over health related activities must be taken away from the "health care" establishment. They argue for a much broader citizen and community involvement in health related issues and for the development of policies and initiatives that will lead to healthier communities. Many European cities have adopted a "healthy cities" approach and a strong effort in America is being fostered by the Health Care Forum in California. This movement is related to the third strand described below.

This third is a move to increase and improve primary and community care services for the entire population. The lack of adequate primary care results in an inappropriate use of specialist doctors and acute hospitals in large cities. More primary care based HMOs and HSOs in North America, the creation of fund holding general practitioners in the UK and more primary care clinics in many other countries increases the demand for primary care practitioners. Policies to enable this include the restructuring and down-sizing of acute hospitals in major cities such as London and Toronto; the increased control by primary care practitioners over the funds spent on acute care for their patients, the increased clinical authority given by law to primary care nurses and other allied health workers in the community.

4.2.1 Community

These movements affect all the faces of health care. Making organizations more local means strengthening the role of the community in health care organizations. Boards will represent a wide range of interests in local communities. In this scenario the opportunities for meaningful board involvement can increase because organizations are smaller and more accessible and systems are simpler. The board can have more understanding of health related issues and the services provided by its organization.

4.2.2 Control

In local health related organizations managers function as CEOs of multi-services centres such as the CLSCs of Quebec. Many of these organizations provide health and social services: everything from local health education to legal advice. Others include alternative primary care practitioners such as chiropractors and acupressure masseurs. The coordination of services and resources in such settings is more manageable especially with stronger local support. The opportunity to change the relationships among the four faces may well depend
more on the particular circumstance of the community. Managers have a clearer mandate for resource allocation from stronger boards. They can set priorities with a more intimate knowledge of community needs and wants. Many hospital managers are already increasing community contact. Others are decentralizing services to the community.

4.2.3 Cure

The shift to increased primary care and care in the community is happening slowly in medicine. Medical education is moving out of the hospital and into the community. Doctors have begun to explore the use of alternative therapies in their own practices. Others have begun to join forces with other primary care practitioners in full service primary care clinics. Payment to doctors has begun to emphasize their role in keeping the populations they serve healthier. Fund holding general practitioners in the UK are already able to use the funds they do not spend on acute care to develop their primary care services.

4.2.4 Care

The nursing profession has widely embraced aspects of a community based idea of health. The Ontario Nursing published an insert in the mass circulation Toronto Star. They used...

"...these pages to promote a concept of health that is sensitive to the needs of people, solidly based in the community, and provably effective." [Ontario Nurses Association, 1993]

The nursing vision of a community oriented future gives nurses two different new roles. Some will engage in a general nursing practice as autonomous primary care professionals in the community. They will be independent practitioners who will develop practices much as medical general practitioners do now. The promise is that because of their nursing training they can do more than traditional general practitioners because they can provide a broader range of services during clinic and home visits. Their career path is to develop a practice in a community.

A second role is as consultants to communities. Their training will allow them to assume many functions in primary and community care and they can become members of various health related work groups. Examples include developing community training programs for pregnant women, consulting to organize healthy communities, planning new community health services and joining multi-disciplinary community health care delivery teams. Nurses have the career paths of independent consultants who move laterally from project to project.

4.3 Rethinking Health Care Work

One way to respond to the dysfunctional cleavages among the four faces of health care and the excessive fragmentation of health care work is to rethink how health care work is done. In recent years quality improvement has incorporated efforts by specially trained groups to review and redesign work processes and then implement the changes. Patient focused care is another method of bringing care closer to the patient by creating smaller more multi-functional care teams - groups of health care workers who work across traditional
functional barriers. These new ways of rethinking processes are most effective when doctors, nurses and managers work with patients and their families. All four faces of health care must together rethink and integrate the work if this approach is to succeed.

4.3.1 Control

A major motivation for managers is the inefficiency that results from fragmentation. Managers can contribute to thinking about work process, can help develop working groups, and support care teams in making improvements in care.

The organization of hospitals into a fragmented functional bureaucracy is a barrier to rethinking the work. Managers have a lead role to play in redesigning the organization to heal the traditional splits between the administrative functions, and between faces of health care. Often the fragmentation is bound up with union and professional interests that must be unravelled before health care can be re-integrated.

The greatest difficulty for managers is to change from control to cooperation with the other faces of health care. In some hospitals this change has been indicated by turning the traditional organizational chart on its head and stressing managers' role as support for the activity of the care teams.

4.3.2 Community

In this scenario representation on boards includes many more patients and family members who contribute to the redesign of work by the care teams. Members of the board are much closer to the work of the organization and might, for example, relate to specific groups of patients or care teams in an ongoing way.

Many boards in health care and in other areas have begun the process of reconfiguring themselves from the more traditional functional committees to ones that relate to particular operating area of their corporations. In health care the patient care committees are still minor and it remains to be seen how the community responds in detail to these shifts.

4.3.3 Cure

The fragmentation of medical knowledge has introduced many new sub-specialties into medicine, but it has also forced different specialists to collaborate. The organ transplant surgeon needs the help of a specially trained anaesthetist, a good immunologist and a physician who specializes in the organ to be transplanted. These multi-specialist teams also contain specialist nurses who help to harvest the organs, do the transplant, and follow the patient for any signs of rejection. Other professionals such as nutritionists and social workers are also joining the teams.

Many medical schools have responded to the overcrowded and fragmented medical curriculum by changing to problem-oriented learning. They have begun to emphasize the natural history of disease and to follow patient care processes more completely [Morris, 1993]. This change in orientation bodes well for a broader rethinking of patient care beyond medical intervention.
Clinical audit, the review of patient care processes, and the revision of care patterns for patients has allowed doctors and others to rethink the delivery of care and to improve the process. Many doctors recognize that such rethinking can re-integrate health care and improve outcomes.

4.3.4 Care

In this scenario nurses will join smaller, decentralized and more integrated teams responsible for all patient care. They will implement and monitor work patterns they design with others. Nurses and other health care professionals will be associated with one or several of these clinical teams and play a clinical role throughout their careers. In this way their practice will be significantly more professional - they will gain a clinical knowledge and as their understanding and skills improve their pay will follow. A leader of such a clinical team will be expected to assume a leadership role and also to remain clinically active.

Because the work will be rethought and shared, the boundaries between disciplines will be reduced. All members of a care team will be able to assume the hands on chores related to patient care, and those who have special technical skills will maintain and improve them in a clinical setting.

Since the clinical teams will be the basic units in which work is done, and will have a high degree of professional autonomy, they will assume the responsibility for auditing their work with a view to improving patient care. Independent review will concentrate on outcomes rather than work processes and rewards to team members will be related to outcomes.

5. Conclusion

It is easy to identify and elaborate the role of nursing professionals in each scenario once the other faces of health care are described. Figure 2 contains a summary of these nursing careers and the range of possibilities emerging from the three possible directions described in chapter 4. It may be of use to those nurses who are considering the future of their profession.
One thing is clear: the role and career of nurses will not remain as it is today. If the traditional nursing career was as a member of a hierarchical career structure, the new possibilities for nursing seem to suggest a variety of roles. It is probable that in the future no one of these will be exclusively true but that some mixture will occur. It is up to the nursing profession to consider each of these possibilities and decide upon the direction they will take nursing education and nursing practice. There is clearly a lot to do.
References


PART IV. Successful Strategies for developing Leadership among Nurses by Tom Keighley

Introduction

Health services across the world are being faced with a number of increasingly varied challenges. Most countries are concerned with how they can improve the efficiency and effectiveness of health services in a context of increasing expectations from customers and a significant change in population profile.

It is within this arena that nursing, as the largest health care professional group, is itself responding in a variety of ways. For, no matter the cultural context of care, there appears to be a commonality of issues, and an identified need to share the good practice which emerges from the development of solutions.

The following represents a summary of contemporary thinking behind just one of these issues, that of Leadership. For, increasingly, the importance of effective leadership is demonstrated as having significant impact on the outcomes of patient care. Equally it enhances the ability of organisations, and the individuals within them, to cope with the extent and rapidity of change which many health care organizations are facing.

1. Leadership and Management - The Relationship

The development of nursing throughout the world has been characterised by peaks and troughs. However, the dominance of a medical model of care within western cultures has had a prolonged and significant impact on the development of nurses who have felt unable to challenge this enduring and powerful view of health.

It is only in recent history that there has begun to emerge the notion of empowerment for both patients and nurses. The impetus for this has had much to do with the introduction of business thinking into the public services.

In response to recession and spiralling demand, Health Services are increasingly reacting like businesses striving to improve performance by adopting styles of management and structures which mirror those of industry. The consequences of these changes has led to a fundamental challenge to the traditional hierarchies of the professions and the removal of large parts of the bureaucracy which supported them.

Increasingly there has evolved a new demand within these services, one for leaders. That this demand came from areas which in the past had not traditionally produced such leaders was obviously problematic. Equally the need to encompass large numbers of women within this thinking called for a new approach for it could be argued the perceived lack of leaders reflected historical underachievement and under investment in the whole area of predominantly female occupations.
1.1 Leadership and Management

This new demand resulted in clearer distinctions being made between the contribution of management and that of leadership. For leadership and management are two distinctive and complementary systems of action. Each has its own function and characteristic activities. Both are necessary for success in an increasingly complex and volatile health service environment.

Successful organisations do not wait for leaders to come along. They actively seek out people with leadership potential exposing them to career experiences designed to develop that potential. Indeed, with careful selection, nurturing and encouragement, dozens of people can play important leadership roles in organizations.

Although the literature is plentiful with references to the major differences, and whilst by definition they do differ, management and leadership can co-exist in an individual. The differential application of these characteristics depends on the situation. Leaders do the right things, managers do things right [Bennis and Nanus, 1985].

Management is about coping with complexity. Its practices and procedures are largely a response to one of the most significant developments of the twentieth Century, i.e. the emergence of large organisations. Without good management complex enterprises tend to become chaotic in ways that threaten their existence. Good management brings about order and consistency to key issues, like the quality and profitability of products.

In contrast, leadership is about coping with change. In recent years, the business world has become more and more competitive, and highly transient. Faster technological change, greater international competition, and the deregulation of markets, over capacity in capital intensive industries, and the changing demographics of the workforce are amongst the many factors that have contributed to the shift. More change demands more leadership.

Stewart (1989) suggests there are three main challenges to leaders in the National Health services (UK). First, to envision what should be done by them, and those who work with them to make their part of the service better. Second, to realise the potential in humane resources. Thirdly, to respond to a more knowledgeable and demanding public. These different functions i.e. coping with complexity and change, shape the characteristic activities of management and leadership.

Organizations manage complexity by planning and budgeting, setting targets or goals for the future, establishing detailed steps for achieving those targets, ultimately allocating resources to accomplish the plan. By contrast, leading an organization to constructive change begins by setting a direction i.e. developing a vision for the future along with strategies for producing the changes needed to achieve that vision.

Stewart (1989) believes that by focusing attention on a vision the leader operates on the emotional and spiritual resources of the organization, on its values, commitment and aspirations. She views the managers by contrast, as operating on the physical resources of the organization: seeing to it that work is done productively and efficiently, on schedule, and with a high level of quality.
Management develops the capacity to achieve its plan by organizing and staffing i.e. creating an organizational structure and jobs for achieving that plan, staffing the jobs with appropriately skilled personnel, communicating such plans and developing monitoring systems. A comparable leadership activity is alignment of people i.e. communicating the new direction to those who can create an alliance to the vision and are committed to its achievement.

Finally, management ensures that plans are achieved through controlling and problem solving, i.e. monitoring the results against objectives in detail, both formally and informally. Whereas, in leadership, achieving a vision requires motivation and inspiration - keeping people moving in the right direction, despite major obstacles to change by appealing to basic but often unrecognized human needs, values and emotions.

2. European Perspective

Nursing leadership is developing differently in different areas. Crudely, it can be divided into four geographical regions:

- Northern Europe including UK, Republic of Ireland, Holland, Denmark, Finland, Sweden, Norway and Iceland;
- Central Western Europe including Germany, Belgium, Austria, Switzerland, Luxembourg and France;
- Southern Europe including Spain, Portugal, Italy and Greece;
- The former Eastern Europe.

What follows is a broad generalization, in order to draw out some marked differences in the leadership models demonstrated by nurses.

2.1 Northern Europe

These countries share a history of centrally structured health services, development resources for nurse leaders and strong professional organizations/trade unions. This has provided both a supply of able nurse leaders and the structures which ensured their graduated development. Since 1945, health services in all these countries have been regularly re-organized. On each occasion, the need for nursing leadership has had to be renegotiated. This is an important observation because it indicates two things:

- that even in countries that value nurses highly for their key contribution to patient care, it is rarely that it is assumed that there will be nursing leadership for those who deliver the nursing;
- that nursing as a process is not automatically assumed to be an issue needing to be addressed in management terms and structures because its complexity and sophistication is hidden from view in the very private world of intimate 1:1 care.
This has led in many of these countries to increasingly sophisticated lobbies emerging at national level to promote the nursing/caring agenda and the consequent need for systems to develop leaders, and organization structure within which they can exercise such leadership. The techniques for such development vary and draw on a mix of in-house and higher education facilities. In part, this has led to a justification of role and competence based on academic achievement as much as organisational delivery.

What is important about this mode is, that despite the history and traditions, the availability of training resources and promotional activities, the position of the nurse leader is always open to review and insecurity. This is profoundly undermining for the individual and demeaning for the function. It has bred a degree of defensiveness and non-cooperation, which often leads to criticism of nurse leaders for retaining a certain distance from the corporate functioning of the organization. The challenge for all parties is to overcome this and effect a better integration of the function and its leadership than has always been the case previously.

2.2 Central Western Europe

Health services in these countries have had more devolved patterns of health service management. In consequence, the debate about the proper leadership of nursing and nurses has been slower than average. This may also be due in part to the nature of the professional organisations, which have poorer trade union focus than in Northern Europe and do not appear to have been as successful in promoting concern about, and education for the management of the process of care. Another element here is that the area is dominated by the French and German languages which do not enjoy the range or depth of nursing literature produced in English and accessed much more extensively and effectively in Northern Europe than in Central Western Europe.

The challenge in this area is the integration of an emergent nursing leadership which receives its development in countries of higher education and has to fulfil its function in health systems geared more purely to meet the needs of medical practitioners than in Northern Europe.

2.3 Southern Europe

The nature of nursing leadership is different again in these countries. In large part, it would appear to be because of the origins of nursing within the religious orders and the subsequent move of influential parts of nurse education into the University world. This has meant that nursing has retained hierarchical structures and recognized leaders. It also means that there are nursing organizations with wide professional agendas and programmed for the development of their members. This has been utilized in all countries to ensure the emergence of several generations of nurses coming forward to fill the available positions.

The challenge for nurse leaders in Southern Europe is negotiating such leadership positions within health service structures often prescribed in law. In contrast to Western Europe, the opportunities for development are in place and because of the University base for senior nurse education, access into the English based literature is achieved. One could believe that nursing is moving up the managerial agenda in these countries and that nurses
will be advancing to occupy a greater proportion of leadership positions in their respective health services.

2.4 Former Central and Eastern Europe

In this region formerly part of the Warsaw Pact, revolution in health care is underway, in the same way that it is in all other aspects of life in those countries. There are varied traditions of nursing and nurse development which influence profoundly the current rate and nature of change. One issue unites all these countries however, and that is shortage of resources. In many respects, this is one to "watch and see". The one cautionary note would be that the extensive use of Western, primarily North Western European agencies to help develop their own health systems, may delimit the influence local culture may have had in defining their services.

As nursing is greatly influenced by local culture, this may have greater consequences over time than one might have assumed at first sight. The challenge for these countries will be to develop nurses and nursing at the same rate at which they appear to be intent on developing medical practice. The link between medicine and nursing is a close one, but managers will need to remember the need for specific development in nursing if the traditions of the nursing profession are to be maximized.

3. North American Perspective

Much of the discussion on leadership in North America has assumed the hospital as a central locus for containing costs. The financial imperative of many health care organizations has seen the development of nurse executive programmes with a significant business management orientation.

However, this is set in a context of increasing concerns about the loss of nursing as business focused nurses become assimilated into the management culture. Courses currently being developed attempt to redress this balance by building back in the nursing component.

Leadership has also been used as a way of tackling shortages in the nurse workforce. This has encompassed a range of initiatives such as increased nurse participation in governance and management, promoting positive images of the nurse and expanding pay ranges based on experience, practice, education and demonstrated leadership. Effective nurse leadership is believed to be associated with increased satisfaction in nurse workforce and raises retention and overall performance.

4. Problems for Would-be-Leaders

The conclusions of most studies on leadership in nursing is that there are too few nurses in leadership positions [Rafferty, 1993]. To some extent, this is due to historical factors. Previous strategies for leadership were characterized by the following:

- a focus on tasks, frequently administrative;
- little value placed on practice development;
not women/ethnic groups friendly;
- promotion away from clinical contact;
- management valued over practice by the system.

This view is supported by work carried out by Rafferty (1993) who cited factors such as language, institutional racism and gender politics as perceived barriers to the development of leaders. Language was viewed as a central issue as it was felt that many of the key elements of nursing were difficult to articulate and therefore "outside" the dominant culture. There was a strong feeling that "the language of nursing" needs to be introduced into the dominant culture if mutual understanding was to be promoted.

5. Developing Nurse Leadership - The Way Forward

For nursing to play its full part in the development of health care services, it is essential that leadership skills are developed within organizations through appropriate planned training and development programmes, based on the recognition of the key importance of leaders and leadership. The search for nurses who have the potential to lead the profession in all activities i.e. practice, research and management, should start very early on in the nursing career.

Leaders are often, though not always, rebels and the passive culture which can exist in nursing may not readily accommodate them. Leadership is partly a function of personality, and it provides the nursing profession with power and motivation to be political and to become a major political force.

Once developed, nursing leadership provides:
- a context for professional development;
- a direction for nurses who are involved in developing strategy;
- a unity of purpose for nurses;
- a base for decision making and objective setting;
- a stimulus for creativity and innovation within all fields of nursing practice, education, management and research;
- a focus for informed debate (RCN 1991).

5.1 Competency

A development programme for nurse leaders needs to be based on some notion of competency. It is highly likely that these will be culturally determined. However, an example of developing frameworks in this area can be seen in the work of Bennis and Nanus (1985). From interviews with 90 eminent leaders in the USA, Bennis and Nanus came up with four areas of competency that all of the sample manifested:
- **Attention through vision** - i.e. creating a focus, being committed to positive outcomes, having attention-grabbing expectations of outcome;

- **Meaning through communication** - i.e. the ability to communicate a compelling image of the desired outcome(s);

- **Trust through positioning** - trust permits accountability, predictability & reliability; positioning is the set of actions necessary to implement the vision of the leader. The leader establishes the environment of trust;

- **The deployment of self** - through positive self-regard and optimism about the outcome.

Additionally, Bennis & Nanus were able to identify that leaders empower others to convert concepts and ideas into reality and then maintain it. They viewed the components of empowerment as:

- **Significance** - the individual feels she/he is making a valued contribution to the organization;

- **Competence** - development and learning on the job;

- **Community** - individuals feel a sense of community with others in the organisation and know they can rely on them and be relied upon.

- **Enjoyment** - the individual enjoys his work and therefore the quality of both work and life in general are increased.

6. **Organizational Development of Nurse Leaders**

The organizational approach to developing nurse leaders, is against a backcloth of corporate support and management development. This approach includes five related, yet independent stages:

1. **Awareness** - of self, of requirements of the role within the organization.

2. **Foundation** - values and skills of current/intended role and the competencies required to deliver that role.

3. **Identification** - getting recognized by appraisal systems or individual endeavour.


5. **Development** - a personal development plan created in line with the corporate requirements.

The key concepts identified incorporate a process of self-development in a learning organizational environment, the key aid to development being a development plan agreed between the individual and the organization’s representative. It is interesting to note that within
the context of that organizational strategy, there is an identified need for the individual to clarify the style of approach required for differing situations i.e. managerial or leadership style.

6.1 An Organizational Approach

![Diagram showing an organizational approach to the development of leaders in nursing]

Showing an organizational approach to the development of leaders in nursing
7. Personal Development Opportunities

Those areas which seem to be making progress in establishing a range of leadership skills within the workforce appear to succeed by providing a range of local opportunities which link to national networks. There is very evidently no one simple solution to answer the wide needs of nurses and the organizations in which they work.

It is beyond the scope of this paper to review the entire range of courses and programmes. However, a number of examples of development opportunities which appear to be able to respond to individual nurses personal needs are given below.

7.1 Mentoring

Mentoring is based on a relationship which is dynamic, reciprocal and can be emotionally intense. Within such a relationship the mentor assists with career development, potentially acting as a teacher, friend, protector or coach, whilst guiding the mentoree through organizational, social and political networks. The availability of female mentors, due to the numbers of women in the power structures, can be problematic for nursing. However, what seems to be important in mentorship is not necessarily the gender of the mentor but his or her position in the power structure.

7.2 Shadowing

Shadowing provides the opportunity for one individual to experience and understand the role and work practices of another in order to improve their own performance, to develop the organization or to try out new employment. Shadowing provides women and minority groups with:

- positive role models;
- opportunities to develop networks;
- awareness of career opportunities in management;
- an understanding of the skills needed to overcome perceived barriers to career development.

7.3 Succession Planning

Succession planning is a formal process which focuses on both the identification and the development of managers or leaders who have the potential to succeed or lead. Succession planning offers benefits to the organization by ensuring the availability of managers who appreciate the organization's mission, values, culture and strategy. It also promotes the organization's image as a caring employer.

Identification of potential talent is not always possible or indeed easy. Succession planning favours internal candidates and can exclude those people with innovative ideas who are outside the organization. The reluctance of some line managers to allow talented people
to develop within a formal structure may inhibit the implementation or success of succession planning.

Hernandez and Haddock (1991) suggest that critical success factors are:

- senior managers must be committed to it;
- senior managers must support its implementation;
- there must be adequate staff support for its activity;
- succession planning must be linked with other human resource systems;
- an adequate human resource system is needed;
- the organizational structures should encourage and support experiential learning, e.g. secondment;
- promotion from within must be accepted;
- line managers may require training in mentoring, coaching, and giving feedback;
- accountability for implementation of development plans should be clearly stated;
- a range of individuals should take part in the assessment/identification process;
- there must be periodic evaluation of the system.

7.4 Action Learning

Action learning is concerned with inducing adaptation and change behaviours in the individual and, by extension, in the whole organization. Margerison (1988) refers to the key elements of action learning as:

- learn from experience;
- share that experience with others;
- have colleagues, within the set, criticize and advise;
- take that advice and implement it;
- review with those colleagues the action taken and the lessons that are learnt.

Learning and action, moderated by feedback systems, are intertwined and Revans (1984) developed the concept of action learning. Learning (L) comprises of two interrelated components: Programmed knowledge (P), and Questioning insight (Q).
As a formula, this would read \( L = P + Q \). Teachers provide the necessary programmemd knowledge, whereas questioning insight engages our experience and our creativity. It may be useful to state that action learning is not necessarily about any of the following methods when used in isolation:

- traditional education system;
- informal get together;
- individual appraisal system;
- simulated role play;
- staff support group.

### 7.4.1 Implementation: The Set

Revans described colleagues working on real problems as "...comrades in adversity", a set of four to ten people who are faced with difficulties or new problems and who have the opportunity to constructively share their concerns and experiences with others. The set requires an adviser, i.e. a senior manager who can start the group, provide direction and act as a resource. She should focus the group towards development. The prime source of help is the peer group, not the set adviser. The purpose of the set is to tackle real issues facing the organization. Items or objectives for set need to be allocated by the organization, thus fostering a sense of senior management support. Target dates for achievements should be agreed within the set.

### 7.4.2 Implementation: The Organization

Action learning should focus on problems for which the manager or sponsor is personally accountable. The extension of individual development (within the set) into organizational development depends on commitment from the top and the interaction between the set and other managers and colleagues in the organization.

Through presentations of the set's own work, senior managers in the organization should examine the results suggested by the set. The aim is to engender incentives for senior managers to revisit working practices, relationship and even organizational structures.

### 7.4.3 Pro's and Con's of Action Learning

Action learning offers personal development within a group. The set can focus on real problems. Action learning is a credible system which has been applied within the NHS. It need not be expensive to set up, the maximal use of internal resources is achieved. However, the group interface may not work, especially if membership is decided on function lines (e.g. a group of people functioning in the same capacity). The meeting of the set members may end up in a protracted gossip shop. Organizationally, the set can be used (or abused) as a dumping group for management's problems. Equally, the solution proposed by the set may be unpalatable to the organization.
7.4.4 Critical Success Factors

- The facilitator must be skilled in handling group work;
- the process must be clarified at the outset;
- commitment from individuals within the set;
- commitment from senior managers;
- clear objectives must be set;
- objectives must have organizational importance;
- target dates for achievements must be set;
- basic skills in set members must not be assumed;
- individuals are not in competition with each other;
- individuals are supportive to each other;
- confidentiality must be respected;
- group safety should allow for self disclosure of personal perceptions;
- solutions must be acted upon;
- solutions must be networked.

7.5 The Lack of Career Planning

Too often in the past, nurses have found themselves in careers almost by chance rather than through a planned choice. The various Health Service reorganizations have brought about a variety of careers for nurses with a greater emphasis on clinical nursing. Opportunities exist in management, education, research and in non-nursing specialities. Careful career planning and access to a career counsellor can facilitate recruitment and retention as well as the realization of potential in nurses. Career development is a process in which:

- goals are set;
- needs are identified;
- counselling and guidance are available;
- plans are implemented;
- activities are evaluated.
8. Professional Development Opportunities

Whilst the previous sections reviewed possible organizational and personal approaches (chapter 6 and 7) to the development of nursing leadership which could potentially be undertaken in a multidisciplinary context, the professional approach to be described in this section promotes uni-disciplinary programmes.

The result is a network of professional leaders. The model of Structure-Process-Outcome is used [see Chart 2].

8.1 Structure-Process-Outcome

Individual nurses can develop confidence, competence and conviction through self-assessment and personal presence (taught course) relating to, for example, self-awareness, emotional expressiveness and developing a personal image (as discussed in previous sections of this paper). This can lead to influencing nursing and general management issues.

To obtain nominations for the forum, managers and others need to rely on peer-assessment and/or "walking the floor" to become personally acquainted with the nominees. Those nurses who have demonstrated educational and clinical innovations in their work are natural candidates for the forum.

8.1.1 Process

The central activity of this process is a networking forum for professional leaders. The group will comprise of student nurses, clinical staff, educationalists and managers who have demonstrated leadership qualities. The range of clinical specialities will be represented. New members will be admitted following recommendation or through self-selection.

Depending on the size of the group, which could be potentially large, the forum may be sub-divided into functional speciality and will meet in a plenary session. The agenda will include:

- vision for nursing (enablement of);
- leadership issues in nursing;
- the implications of national and regional policies;
- clinical and educational issues;
- agreeing competency framework.

The function of this forum and its sub-groups is the informal support of the executive work of Chief Nurses.
The professional approach

Self Assessment
Personal Presence
Identification:
Nomination from Units of Management

STRUCTURE

FORUM FOR PROFESSIONAL LEADERS

COMPETENCY
Vision for Nursing
Educational Issues
Leadership
Clinical Issues
National regional Policies

PROCESS

NETWORK OF LEADERS

Advancement of Clinical Nursing
Role Models/Mentors
Promotion of Diversify of Nursing
"Think-Tank"

OUTCOME

Showing a professional approach to the development of leaders in nursing
8.1.2 Outcome

The output of the activities of the forum for professional leaders will be peer group recognition, acceptance and self-esteem. The forum will spend much of its time debating professional issues. It will also address the development needs of its members. With a powerful membership and agenda to articulate the mission and provide the strategic thinking concerning professional issues of senior nurses, the forum will subsequently be regarded as a club of leaders. It should also serve as a recruitment ground for the profession; members will hold or aspire to hold key positions within organizations.

The network (forum or club) of leaders will potentially:

- advance clinical development in nursing;
- provide the models or mentors for nurses;
- celebrate the breadth of the range of nursing activities;
- provide a "think-tank" for the profession.

9. Conclusion

The need for leadership in nursing has never been greater and yet, as we have seen, its ability to flourish and contribute to the change agenda is still the subject of debate by policy makers.

The inherited lack of commitment to the development of a "minority" voice within traditional power structures necessitates a fundamental shift in values. This radical rethink needs to occur in areas where there are strong forces working to maintain an equilibrium which mitigates against risk, innovation and change.

Nurse leaders of the future will be visionary, political and willing to take risks in order to achieve the goals of the organizations they work within.

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