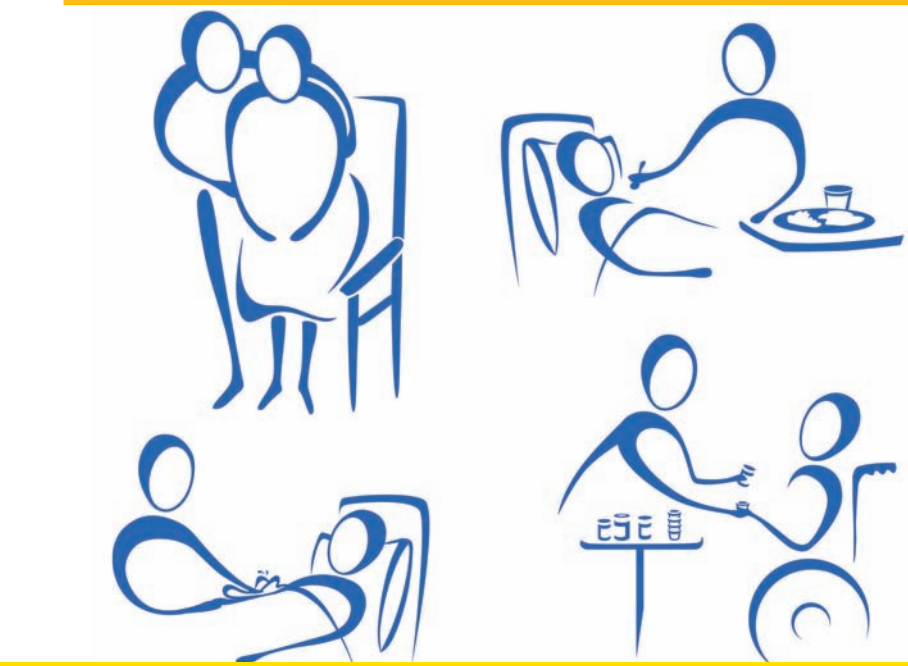
STUDIES IN PROFESSIONAL LIFE AND WORK

European Nurses' Life and Work Under Restructuring

Jarmo Houtsonen and Gun-Britt Wärvik (Eds.)



SensePublishers

EUROPEAN NURSES' LIFE AND WORK UNDER RESTRUCTURING

STUDIES IN PROFESSIONAL LIFE AND WORK
Volume 2

Scope
The series will commission books in the broad area of professional life and work. This is a burgeoning area of study now in educational research with more and more books coming out on teachers' lives and work, on nurses' life and work, and on the whole interface between professional knowledge and professional lives.

The focus on life and work has been growing rapidly in the last two decades. There are a number of rationales for this. Firstly, there is a methodological impulse: many new studies are adopting a life history approach. The life history tradition aims to understand the interface between people's life and work and to explore the historical context and the socio-political circumstances in which people's professional life and work is located. The growth in life history studies demands a series of books which allow people to explore this methodological focus within the context of professional settings.

The second rationale for growth in this area is a huge range of restructuring initiatives taking place throughout the world. There is in fact a world movement to restructure education and health. In most forms this takes the introduction of more targets, tests and tables and increasing accountability and performativity regimes. These initiatives have been introduced at governmental level – in most cases without detailed consultation with the teaching and nursing workforces. As a result there is growing evidence of a clash between people's professional life and work missions and the restructuring initiatives which aim to transform these missions. One way of exploring this increasingly acute clash of values is through studies of professional life and work. Hence the European Commission, for instance, have begun to commission quite large studies of professional life and work focussing on teachers and nurses. One of these projects – the Professional Knowledge Network project has studied teachers' and nurses' life and work in seven countries. There will be a range of books coming out from this project and it is intended to commission the main books on nurses and on teachers for this series.

The series will begin with a number of works which aim to define and delineate the field of professional life and work. One of the first books 'Investigating the Teacher's Life and Work' by Ivor Goodson will attempt to bring together the methodological and substantive approaches in one book. This is something of a 'how to do' book in that it looks at how such studies can be undertaken as well as what kind of generic findings might be anticipated.

Future books in the series might expect to look at either the methodological approach of studying professional life and work or provide substantive findings from research projects which aim to investigate professional life and work particularly in education and health settings.

European Nurses' Life and Work under Restructuring

Edited by

Jarmo Houtsonen
University of Joensuu, Finland

and

Gun-Britt Wärvik
University of Gothenburg, Sweden

SENSE PUBLISHERS
ROTTERDAM / BOSTON / TAIPEI

A C.I.P. record for this book is available from the Library of Congress.

ISBN 978-90-8790-980-2 (paperback)
ISBN 978-90-8790-981-9 (hardback)
ISBN 978-90-8790-982-6 (e-book)

Published by: Sense Publishers,
P.O. Box 21858, 3001 AW Rotterdam, The Netherlands
http://www.sensepublishers.com

Printed on acid-free paper

CONTENTS

PREFACE

The basis of this book is the European-wide research project entitled *Professional Knowledge in Education and Health: Restructuring Work and Life between State and Citizens in Europe* (http://www.profknow.net/). The project was financed by the European Union 6th Framework Programme, Priority 7, Citizens (Contract No. 506493). The overarching ambition of the PROFKNOW project was to understand knowledge "at work" among teachers and nurses as professional actors situated between the state, on one hand, and the citizens, on the other. Seven countries participated in the project: England, Finland, Greece, Ireland, Portugal, Spain and Sweden.

In this volume, parallel to the book on European teachers, the authors of the chapters use the outcomes of the project as a platform for further reflection on their research and to deepen their analyses. The focus is still on the changes in welfare states and restructuring of health care systems examined from the perspective of the nurses' experiences. However, the authors had the possibility to concentrate, from different theoretical approaches, on a specific problem area related to the main concerns of the original project.

There are many people whom we would like to acknowledge. First of all the project would not have been possible without the voluntary contribution of nurses and other health care staff in the seven participating countries. Regardless of their work load and hectic daily schedules, they were willing to participate in interviews and observations.

Many researchers have been involved in the PROFKNOW project, some of them directly in the research and others offering advice and commentary. They have all contributed to making this book possible. In particular we would like to thank Sverker Lindblad, who coordinated the PROFKNOW project, and Ian Perry, Principal Administrator at European Commission DG Research in Brussels. We also thank, in alphabetical order: Ari Antikainen, Jorge Ávila de Lima, Amalia Creus, Nasia Dakopoulou, Xavier Giró, Ivor Goodson, Fernando Hernández, Verónica Larrain, Erja Moore, Max Muntadas, Caroline Norrie, Ewa Pilhammar Andersson, Juana M. Sancho, Giannis Skalkidis, Areti Stavropoulou, Ciaran Sugrue, Dimitra Thoma, and Evie Zambeta.

We hope this book will provide new knowledge and insights not only to academic social scientists, but also to managers and practitioners working in the fields of health care and nursing.

Jarmo Houtsonen and Gun-Britt Wärvik
Editors

JARMO HOUTSONEN & GUN-BRITT WÄRVIK

INTRODUCTION

This book is about how European nurses' conceive their work and life in the midst of structural changes in welfare state, health care systems and nursing profession. Because our book focuses on nurses' experiences of and responses to structural changes, we need to locate nurses' work and lives within broader historical and social contexts. Therefore, as a background for the following chapters, we offer in this introduction a brief description of the globalization processes and the welfare state transformations, and how these are related to health care systems and the nursing profession. We also present some general methodological points that guided the research that contributed to this book. In conclusion, we summarize briefly the content of the book.

While we were editing this volume the world experienced a massive financial crisis followed by decreased investment, production and trade. No one seems to know yet how deep the slump will be before we move on to a new growth-track. Economic decline means that publicly financed welfare services are greatly strained since tax revenue falls. Consequently, health care systems may face new demands to cut costs and streamline. However, the current economic downgrade has also challenged the prevailing ideas concerning the organization and regulation of the capitalist free market economy. This ideological change might also bring about a disbelief in applying the market mechanism to the production and delivery of welfare services such as health care. For the moment we do have no idea about which way different countries may be heading.

WELFARE STATE AND GLOBAL CAPITALISM IN THE 21ST CENTURY

Welfare state and capitalism are closely connected. The emergence of the welfare state can be regarded as a compromise between class conflicts and distribution of prosperity and wellbeing among the various groupings of citizens in order to achieve a more equal society. Today, global economic competition is commonly used in policy discourse to argue for restructuring and trimming the welfare state so as to maximize cost-efficiency and utility for both capital and labor, or for both business and consumers. Some authors, such as Deacon (1997), have argued that welfare states are competing against each other, accompanied by international organizations and global discourse on supra-national policy issues, in order to regulate capitalism and protect the welfare services. However, if we assume that the welfare state provides a politically more or less neutral infrastructure for an innovative and competitive society, then there is a danger that we may not see the actual or potential

J. Houtsonen, G.-B. Wärvik (Eds.), European Nurses' Life and Work Under Restructuring pp. 1-13.

conflicts between capital and labor or between social classes or various interests groups in general. These conflicts are fought not only within states but also between states. The ambitions to abolish inheritance tax in many Western countries and the brain drain in the form of educated nurses from less-developed countries such as Malawi moving to the prosperous West are just two examples that illustrate how these conflicts cross national and international borders.

Koch (2008, 60-2) points to two important structural adjustments in the transition of welfare state in the face of trans-national capital accumulation at the turn of the 21st century. First, some of the authority in public regulation and decision-making previously held to the state has been increasingly taken over by, or given to, supranational bodies such as the UN, OECD, WTO, EU and World Bank. Second, the idea and practice of state regulation has changed from "government" to "governance". This means that there has been a delegation of authority to expert and non-governmental bodies and regional organizations, and the establishment of various public-private partnerships. In addition, the state does not so much monitor directly the welfare services provided by public organizations as it sets goals and benchmarking criteria and acts as a moderator and a collaborator between various constituents and interest groups. Moreover, voluntary associations and private firms are increasingly producing the welfare services for the "markets" where public organizations operate as purchasers.

The nexus between globalization, welfare state, health care and nursing profession can be approached from competing stances and projections (see Goodson & Norrie 2005). According to Brady et al. (2005, 923), so-called "welfare state reduction literature" holds that the transformation of global capitalism and the emergence of neo-liberalism as a dominant ideology have restructured the relations between the economy, society and policy and has rendered social welfare systems more feeble (see also Fairclough 2004; Mishra 1999). It is said that this transformation provides opportunities for the exploitation of uneven power relations between various fractions of society and threatens to increase the division between rich and poor people and nations. However, some argue that since globalization is also accompanied by global networks of human rights and justice, there are also discourses about the possibility of increasing, or at least protecting liberty and equality (Castells 1998).

Some authors argue that nation-states have become obsolete and have been taken over by multinational corporations and international and regional regimes (Barrow 2005). Others argue that the welfare states are just readjusting themselves in the face of global demands, and that welfare services are protected by strong interests and institutions (Esping-Anderson 1997). Still others, focusing on particular welfare institutions, see that welfare states are converging in the face of global demands, but only to a degree because of diversity in national strategies and historical path-dependent development (Antikainen 2008; Koch 2006; Mills et al. 2008). Consequently, many authors seem to believe that social policies tend to bow to markets and the exigencies of competitiveness (Koch 2008, 60). However, some empirical studies suggest that the harmful effects of globalization on the welfare state are not necessarily as strong and as all-embracing as assumed (Brady et al.

2005). The conclusion that can be drawn is that we do not yet have a complete picture of these structural transformations, their causes and outcomes.

When we look more closely at how these general welfare state restructuring trends are re-contextualized in health care systems in different national settings, we see that there is a strong emphasis on cost-efficiency, mangerialism and quality control (Dent 2003), which have impact on the organization of health care and nurses' work. For instance, Rafferty (1996) argues that 'new knowledge regimes' have emerged to manage and control the costs by means of health economics, evaluation and auditing as well as evidence-based medicine, clinical practice guidelines and health technology assessments. These influences are not confined to the Anglo-Saxon world alone, but have been at least partly adopted in many other Western countries as well. We should point out, once again, that there are national variations and path-dependent developments in health care policy and structures. Nevertheless, it seems that all states are trying desperately to balance their budgets and to adjust as competitively as possible to international corporations' efforts to globalize their profit-making and capital accumulation. This involves, among other things, tighter public spending and lower taxes, which both contribute to increasing cost-efficiency criteria and the rationalization of work in health care systems.

These structural changes put pressure on health care personnel all over Europe. In this book, we want to examine what happens to nurses' work and life when they are expected to adjust to these new demands. How do the European nurses experience these changes? Do they adapt or resist? The consequences of these structural changes in the working lives of nurses could be manifold. Kirpal (2003), for instance, suggests that one possible outcome is an increasing conflict between the professional identity rooted in the idea of patient-oriented care and the efficiency demands introduced by various managerial and organizational reforms.

STUDYING RE-STRUCTURING AND PROFESSIONAL WORKING LIFE

In this book, we do not focus on the causes of the structural changes, nor do we want to construct typologies of different countries on the basis of pertinent differences and similarities. Rather, we want to understand what happens in nurses' work and life in different localities when new restructuring measures are introduced in health care organizations. We also want to know how nurses experience and respond to these structural changes.

Restructuring refers to the changes in policy, regulation and administration of health care institutions, organizations and services. As we said above, the widespread neo-liberal and new public management doctrines and policies drive these changes causing some convergence in national health care systems. When we examine the local practices, we see that the processes and outcomes of restructuring vary across the national contexts. Even though there is convergence, perhaps due to the common driving forces of restructuring, different histories of each health care system and profession, and particularities of administrative measures and their implementation contribute to how this common trend refracts in each respective context, producing

different outcomes at the level of various localities and nurses' everyday work (Goodson & Norrie 2005). Moreover, it is not only the calls for economic efficiency and professional accountability, but also the rationalization of administration (bureaucracy) and scientific and technological progress, and other societal changes, such as immigration and graying European population that contribute to the change in nurses' working life (Kosonen & Houtsonen 2007, 11).

Our book focuses particularly on professional life, work and knowledge from a bottom-up perspective. Consequently, we concentrate on practical and situational aspects of work and the issues that are meaningful for the nurses themselves without forgetting the broader structural changes. In the PROFKNOW project, we analyzed the issues that nurses talked about in interviews by means of a set of common themes including working conditions, control and autonomy, social relations, social position and status, education and learning, working-life balance and professional knowledge and expertise. By looking at the nurses' actions, perceptions and experiences from a bottom-up perspective in their respective localities, we want to analyze how restructuring measures are materialized, enacted or even resisted by nurses. Moreover, we aim to analyze the extent to which these measures are re-contextualized as new conceptions of professionalism and knowledge.

As mentioned above, there has been some convergence in the major structural changes in the governance, financing and labor management of health care in each country in the past twenty years or so (Beach 2005; Goodson & Norrie 2005; Kosonen & Houtsonen 2007). This convergence has not been universal or all-embracing in every sector of welfare (see Antikainen 2008; Koch 2006; Mills et al. 2008). But when we look at the general pattern of welfare state formation and change in health care, we can discern the following pattern. First, there was the establishment of universal, centralized and state-governed, and mostly tax-financed free health care systems. Then there was a noticeable transformation of the system due to neo-liberal trends of cost-efficiency, rationalization of administration, standardization of practice and accountability of professional work. However, the path and pace of this general pattern of change differs in each national case. Accordingly, we can talk about refraction of welfare state restructuring (Goodson & Norrie 2005).

In order to examine the differences between the countries, we divided them on the basis of appropriate properties into three groups. We were aware of the other typologies of welfare states presented in previous research (see e.g. Arts & Gelissen 2002, 143-4, 149-50). Because our main aim was not so much to distinguish between the types of welfare states, but to look at the nurses' working life from a bottom-up perspective we wanted to use fairly neutral typology. In this respect, the countries were classified into three types, the Offshore (the UK, Ireland), the South (Greece, Portugal, and Spain) and the North (Finland, Sweden) (Beach 2005). These categories correspond roughly to earlier categories of Liberal (Anglo-Saxon), Social-Democratic (Scandinavian), and Latin Rim (Late Female Mobilization), respectively (see Arts & Gelissen 2002, 149).

Even our simple classification is not without problems because each country has had its particularities in the welfare state trajectory. For instance, in the UK,

liberalization trends started comparatively early on, in the 1980s, whereas the well-known socio-economic trajectory of Ireland has been unique. Nevertheless, in the literature, both countries are commonly placed in the Anglo-Saxon/Liberal category on the grounds of similarities in policies and institutions. In Finland, the welfare state began to emerge in the 1960s, picked up speed in the 1970s and reached its peak in the late 1980s. Restructuring measures were first introduced at the turn of the 1990s. As a Nordic welfare state, Sweden has preceded Finland in almost all these transformations. Finally, although Greece, Portugal and Spain were all under totalitarian regimes until the 1970s and only after that were welfare state institutions gradually introduced, they all have their national particularities.

As regards the neo-liberal and new public management policies and discourse, the UK has been at the forefront. Neo-liberal measures were introduced there already during the Thatcher era at the beginning of the 1980s. The Southern countries, on the other hand, have never achieved the scale of welfare services in the UK, Finland and Sweden. Nonetheless, there too some restructuring measures are striking. Finland and Sweden, for their part, have been relatively slow to adopt neo-liberal policies in any orthodox fashion. Furthermore, some special restructuring measures, such as contracting of staff, financing hospitals on the basis of results or rankings, or evaluation of process and outcomes, have had a profound influence in some countries but not others.

The transformation of welfare state institutions and professional organizations and practices is not, however, driven only by neo-liberal or economic concerns, but there are at least three inter-connected domains in operation. First, there is a neo-liberal ideology of free markets and economic efficiency. Second, there is an idea of rational management and administration. Third, there is modern medicine based on scientific evidence. These three domains all have their own principles, expertise and authority, which may also be antagonistic when the problems related to structures, policies and activities of health care systems are negotiated. Although these domains can be relatively independent they all are aspects of general rationalization and modernization of the West (Weber 1978) and therefore they may also often go hand in hand quite well. For example, formally rational administrative rules can be used to support the attainment of economic goals. Socio-technological management methods with ICT applications may make it easier to introduce certain efforts of cost monitoring and cost cutting. Evidence-based medicine can provide standards that are easier to relate to rational administration and economic calculation. It seems that at present, the economic domain with the neo-liberal interpretation of economy is dominating the administrative and scientific domains.

These changes mean that for nurses, caring and medical knowledge alone are not enough, they increasingly need administrative, managerial and even financial competencies in order to keep their organizations functioning and to maintain social legitimacy in the face of patients, colleagues, administrators and employers. That is, nurses' everyday working life is surrounded by medical (science), economic (efficiency) and administrative (bureaucracy) demands and expectations. These demands may come in varying guises, combinations and strengths in different

national contexts. Furthermore, nurses may differ in their tendency and capability to recognize, activate or resist various demands and expectations. They also have varying resources and interests to adjust to or resist institutional calls for order.

General policies and discourses may still be rather distant from the everyday working lives of the nurses. Yet when these policies and discourses are being transformed into more concrete measures, such as evaluation and auditing of work, multidisciplinary health care teams or 'profit responsibility', they have a firmer bearing on nurses' work. In this book, we are mainly interested in those institutional changes that emerge as being influential or significant for nurses' working lives, identities and knowledge. Moreover, we focus on how structural and institutional forces are re-contextualized in the everyday working world of the nurses in various European contexts. Hence, it is possible that some of the restructuring measures are totally ignored by local actors or that local conditions and professional judgment produce outcomes that are contradictory to economic notions of efficiency, the administrative notions of rationality and the scientific notions of truth (Freidson 2001), or even public expectations of trust, communication and safety.

METHODOLOGICAL CONSIDERATIONS

When we try to analyze nurses' working life experiences in the context of the restructuring of the welfare state, we need to conceptualize the relation between social agency and social structures. At the level of working life, we think that it would be fruitful to view the process of re-structuring as an encounter between institutions and agents (Bourdieu 1981). Thus, we see nurses' work as socially conditioned practices that "bring together two states of history: objectified history … and embodied history" (Bourdieu 1981, 305). Objectified history, or institutions, consists of rules, procedures and artifacts. Reforms in health care re-define objectified history and pose new expectations and demands with regard to nurses' work. The new restructuring measures are often objectified into texts, buildings and offices and are backed up by directives, job descriptions and training schemes. We understand embodied history as historically and socially formed dispositions pertaining to social agents' ethical, corporeal and cognitive tendencies, with an inescapable bearing on practice. Dispositions, acquired particularly in professional education and socialization, are manifested, for instance, with preferences for a particular job, styles for performing tasks, and in ways of dealing with equipment, expectations and job requirements.

Both institutions and dispositions are activated only if there is a reciprocal attraction between objectified and embodied history. Indeed, agents can work with institutional rules, procedures and artifacts only if they are inclined to do so as a result of previous experiences and training, or more precisely, to the extent and in a manner that their dispositions have been adapted to the institutional requirements beforehand (Bourdieu 1981, 2000). This means, for instance, that new efficiency measures such as evaluation of nursing are ineffective if they are not taken seriously by the nurses. Or, as Hargreaves (2005, 970-4) argues in the case of teachers, early

career nurses are probably more enthusiastic and adaptable to change because they have been prepared for reforms in their training and have no experience of any previous change.

The health care sector consists of divergent institutionalized rules and procedures, belonging to medical (science), economic (efficiency), administrative (bureaucracy) and socio-cultural (patient) spheres that impose divergent mindsets on nurses' work. Different health care organizations and nurses are more or less well-prepared to adequately respond to the often inconsistent demands. In general, social agents differ in their tendency to recognize and activate the historical forces and logics embedded in institutions. There are different ways of experiencing nurse-hood since individual dispositions are formed in divergent social conditions through differentiated experiences and training. In addition, nurses follow varied trajectories and occupy distinct positions in health care systems with different resources, constraints and interests in adjusting to various institutional calls for order.

There are more institutionalized roles, functions and career paths for nurses today than ever before. There are, for instance, numerous medical specializations, and a division of labor between hospitals, primary care centers and teaching institutions and public and private care providers. It is practically a miracle that most individuals find their own place where they "feel at home" in this social mosaic. Collective expectations inscribed in a particular position and subjective hopes embodied in dispositions are usually in harmony due to various mechanisms of self-exclusion and co-optation in the training, recruitment and career of nurses (Bourdieu 2000, 216-8, 231-4; 1981, 308-13). For instance, the mechanisms of self-exclusion ('this is not a job for me') and selection ('he is the right type for this job') operate in the recruitment processes. There are, however, certain forces of social inertia inscribed in dispositions that may come to light when new expectations, introduced by institutional reforms, do not quite match the existing dispositions. Then, old understandings, aptitudes and skills seem to be passé or difficult to realize under new conditions (Bourdieu 2000, 159-61). This encounter between objectified and embodied history may produce various outcomes such as resistance, adaptation or disregard. These encounters – in the context of welfare state restructuring, changes in health care sector and nurses' work and life – are the focus of this book.

Although health care is organized by authoritative rules and we conceptualize practices as preconditioned by history and society, we try to avoid entirely deterministic accounts and leave space also for chance, strategic action and cognitive indeterminacy. There is always some room to maneuver, even in the context of standardized institutional and organizational prescriptions, such as clinical guidelines. In addition, jobs differ in terms of how narrowly and strictly they are defined and how much leeway is given to define rights and duties according to an officeholder's more specific likes and dislikes. Finally, the scarcity of resources may not make it possible to apply orders and guidelines at work. Indeed, the reality of institutional change cannot be found in the formal structures and static analysis of dispositions alone. Practical agents can neither create the principles and resources of

their practices from scratch nor comprehend and control all the social, institutional or dispositional conditions of their practices (Bourdieu 1990, 126-7).

At a certain level, our book can be regarded as a cross-national study of nurses in the UK, Finland, Greece, Ireland, Portugal, Spain, and Sweden. This book in based on seven national reports and a common report on nurses' work and life (see Kosonen & Houtsonen 2007). The data on the national reports came from observations and interviews. We also conducted representative survey research in Finland, Ireland and Sweden involving 1,100 nurses and teachers in each country (see Sohlberg et al. in this book). A total of 4,519 individuals answered the questionnaire. The survey instruments and the variables are presented in the main report (Sohlberg et al. 2007). In addition to these reports, the project has also produced a cross-professional comparative report (Goodson and Lindblad 2008).

The study sites in each country were typical urban multicultural public health care settings where nurses interact with clients and other health care staff. We focused on two primary care settings and five hospitals. We selected three nurses from each country to participate in our study in order to have a representative of the following professional "generations": 30 years, between 8 and 10 years, and about a year of work experience. The national studies started with life story interviews to produce free flowing narratives of professional lives. These were followed by thematic interviews with a common set of themes, such as working conditions, work-life balance, knowledge sources, relations to colleagues and clients, and professional status and autonomy. Finally, ethnographies were produced by shadowing each nurse for three days at her place of work. In addition to this, the partners, except in Finland and Ireland, conducted focus group interviews with other nurses in order to further explore data obtained in the observations and interviews of individual representatives. Obviously, in our qualitative case studies, with just a few participants from each country, our data on nurses' work are limited. However, previous research reports from the PROKNOW project (Beach 2005; Goodson & Norrie 2005) produced extensive literature reviews, which offer us additional information that can be compared and contrasted to our findings.

There are two generic types of comparative study, which can be differentiated by the size of the sample, analysis techniques and strategies for generalization. First, there is the large-scale social survey that is analyzed by means of statistical techniques and generalizes on the basis of statistical significance. Second, there is the qualitative case study with few cases, and the generalizations of which are based on authenticity and credibility of results (Mills et al. 2006, 621-2). The application of qualitative methods to data analysis can be further divided into two types of orientations. First, there is a rather formal and analytical examination of data by using various tables and matrices. For instance, Ragin's (1987) Qualitative Comparative Analysis (QCA) of macro social events and processes belongs to this type. QCA tries to analyze necessary and sufficient conditions, measured as a constellation of dichotomous independent variables, with values 1 if an item occurs and 0 if an item does not occur in order to understand causal mechanisms that produce a particular outcome, which is also measured as a dichotomous variable.

Second, there is a less formal and more descriptive and interpretive understanding of the data, which we mostly employ in this book. For instance, Lindblad and Popkewitz (2003) ethnographically compare educational systems in eleven countries and show how classifications and categories for distinguishing people and social groups are constructed globally and emerge locally. This type of comparative understanding of cases does not, however, signify empathetic understanding or interpretation of intentions of agents. Instead, it presupposes contextualization of primary qualitative case data with secondary evidence, which comes in various forms, such as official statistics, professional and administrative discourse, previous studies and the immersion of the researcher in the socio-cultural context in which the cases are located. This type of understanding also depends on simplification and typification of cases as well. This means that each case that belongs to the studied set of cases is depicted so that only the pertinent characteristics are emphasized and in this way the case is assigned a distinguishable place within the set of cases. Naturally, the characteristics that best discriminate between the cases change when the topic and the focus of study changes. With this strategy, some of the richness and complexity of details is obviously lost, but by highlighting the most pertinent differences and similarities between the cases our understanding both of the broader forces, even at the global level, and the specific cases becomes more profound.

In the following chapters we will see that there are similarities and differences across the countries regarding how restructuring has changed the working conditions of the nurses and how the nurses have responded to these changes. However, we do not only try to typify our cases on the basis of pertinent differences, we also want to show what general outcomes are possible across Europe. Indeed, in line with Nermo (2000), we argue that important similarities can easily be overlooked when we are searching for differences in cross-national comparisons. Nurses' work, tasks and functions are to a large extent similar across Europe, as are the health care institutions, hospitals and health centers and their functions. Our descriptive approach to comparison is also intended to contribute to understanding the changes across the countries, instead of just bringing up the pertinent differences and leaving other details out by reducing the data to the features that distinguish the cases. Thus, we have tried to understand how the cases, on the one hand, converge especially due to global influences, and on the other, refract due to local particularities and histories.

ORGANIZATION OF THE BOOK

In the opening chapter, *The Socialisation and Commercialisation of Health Professions in Europe*, Dennis Beach discusses welfare state restructuring and trends in neo-liberal policy on a more general level, and with implications for health care and nursing. His point of departure is national case reports from the PROFKNOW project, but the scope Beaches' study is broader as he aims to analyze changes in the European service sector from a Marxist standpoint. He identifies a consistent pattern of similar processes of managerialisation, de-regulation, de-centralisation and

rationalisation through standardisation in health care across the countries. The role of the state has been central in these processes of public to private transformation in production relations in health services and commodification of nursing labor power. Nursing has become productive labor that creates economic value and makes a profit. He summarizes the main restructuring tendencies in each country and argues that "nursing has developed as a practice that is increasingly organized and run according to basically equivalent neo-liberal standards, economic thinking and 'a Schumpeterian', market oriented open economy."

In the next chapter, *Nurses' Working Life Under Restructuring*, Peter Sohlberg, Magdalena Czaplicka and Sverker Lindblad analyze and compare the situation of nurses in Finland, Ireland and Sweden on the basis of PROFKNOW survey data. Their aim is to capture restructuring processes from the bottom-up perspective by taking into account nurses' opinions and attitudes as regards matters such as their education, working conditions and work organization. However, the authors also argue that restructuring cannot be captured simply by changes in numerical variables alone. They therefore develop an analytical conceptual framework with the ambition of contextualizing aggregate data in structural tendencies of the system-world (Habermas). In addition, they use the concept of organizational inertia, "based on the assumption that every organization /…/ have to handle the balance between stability and change," to analyze struggles concerning symbolic capital and uneven distribution of resources and power (Bourdieu). The outcome of structural changes is a growing demand for formal qualification of nurses and diminishing influence of professional knowledge. There is also a discrepancy between the subjective experience of control of work and the actual influence on decision-making.

The chapter by Beach relies heavily on the analyses of national policy documents (Beach 2005) whereas the analysis by Sohlberg et al. is mainly based on the survey data (Sohlberg et al. 2007). The next four chapters, on the other hand, originate from the national case study reports, which were based on ethnographic and interview data (Kosonen and Houtsonen 2007). The first three chapters compare all seven countries, whereas the last chapter focuses solely on Ireland and Sweden.

The aim of the chapter by Jarmo Houtsonen and Toni Kosonen, *European Nurses Articulating Care*, is to describe how the nurses in the seven PROFKNOW countries articulate the idea of nursing care. They discuss the diversification of nursing roles and work tasks all over Europe in recent decades. They describe nursing practices as being more varied across contexts, with ambiguities attached to nursing care against the backdrop of changing health care organizations. The nurses' perception of care is mainly two-fold, representing a division, although loaded with ambiguities, between instrumental versus expressive components of care. In addition, a parallel division between bio-medical and humanistic components was found in the nurses' talk about care, "reflecting the various epistemic sources of nursing science." Nursing is a dynamic configuration rooted in the changing organization of health care and division of labor between health care staff. Nursing is not just emotional labour or patient-centred care, but includes many technical, medical and administrative tasks too.

In their chapter, *New Management, Control and Autonomy*, Isaac Marrero and Jörg Müller discuss health care, nursing and New Public Management, which has introduced various measures of cost-control and accountability in health care. They analyze an apparent paradox between increasing professional autonomy and increasing professional control, and how such ideas have affected nurses' everyday work. Their argument is that the situation should not necessarily be seen as paradoxical but instead as a fundamental feature of a new professionalism created by managerial redefinition of autonomy and control. They also point out differences between the seven case studies from the PROFKNOW project in this respect. Moreover, they argue that nurses have gained more autonomy in caring tasks *doing* but have not gained control over administration and management *governing*.

The questions highlighted in a chapter by Helder Pereira and Constantina Safiliou-Rothschild *Emerging Work Transitions in the Nursing Profession* concern changing working conditions and how these are connected to nurses' definition of appropriate roles at work. They focus on problems related to health care restructuring expressed by nurses that cause stress and heavy workloads affecting both professional practice and working life. For instance, the shortage of time for nursing care, related to the shortage of staff, lack of resources and new administrative demands, has had a negative influence on nurses' professional identity. They also discuss new forms of employment contracting for nurses that are also emerging across Europe and the increasing entry of men into nursing, which seems to be changing the idea of caring. They conclude that in the present circumstances, nurses do not find conditions appropriate for working according to their professional ideals, such as holistic care and patient advocasy, because health care organizations do not share these ideals.

Finally, the chapter by Gun-Britt Wärvik, Rita Foss Lindblad and Maeve Dupont, *Patient Orientation of Nurses and Restructuring of Health Care*, discusses the consequences of health care restructuring for Irish and Swedish nurses by taking patient orientation of nurses as the point of departure. They make a distinction between relational, legislative and economic aspects of patient orientation and argue that these aspects should not be mixed up when analyzing implications of health care restructuring from the perspective of nurses. A conclusion is that economic incentives are attached to patient-orientation of nurses, linked to manpower issues in the Irish case study, and to nurses' documentation of their work with patients in the Swedish case.

To conclude, all the chapters discuss nurses and their work during a period of health care restructuring, both in terms of system narratives and life-world narratives (cf. Goodson & Lindblad 2008). That is, we want to understand nurses' experiences and reactions in the context of current changes in health care systems. Moreover, we want to show both the similarities and differences across the countries. The ambition of this book is to point to the general complexities and ambiguities related to nurses and their work, but also the unique situations in which these complexities and ambiguities are embedded. Our hope is that the book can contribute to the discussion of and research on the work and life of European welfare state professionals in general and nurses in particular.

REFERENCES

Antikainen, A. (2008). Power, State and Education: Restructuring and the Nordic Model. In J. Houtsonen & A. Antikainen (Eds.) *Symbolic Power in Cultural Context. Uncovering Social Reality*. Rotterdam/ Taipei: Sense Publishers, 85-97.

Arts, W. & Gelissen, J. (2002). Three Worlds of Welfare Capitalims or More? A State-of-the Art Report. *Journal of European Social Policy*, 12(2), 137-158.

Barrow, C. W. (2005). The Return of the State: Globalization, State Theory, and the New Imperialism. *New Political Science*, 27(2), 123-145.

Beach, D. Ed. (2005). *Work-package 2: Welfare State Restructuring in Education and Health Care: Implications for the Teaching and Nursing Professions and their Professional Knowledge*. Deliverable 2 in the EU Sixth Framework Programme Project Professional Knowledge in Education and Health: Restructuring Work and Life between the State and the Citizens in Europe. http://www.profknow.net/files/results/WP2.pdf. [Accessed June 2, 2008].

Bourdieu, P. (2000). *Pascalian Meditations*. Cambridge: Polity Press.

Bourdieu, P. (1990). *The Logic of Practice*. Stanford: Stanford University Press.

Bourdieu, P. (1981). Men and Machines. In K. D. Knorr-Cetina & A. V. Cicourel (Eds.). *Advances in Social Theory and Methodology. Toward an Integration of Micro- and Macro-Sociology*. Boston: Routledge & Kegan Paul, 304-317.

Brady, D., Beckfield, J. & Seeleib-Keiser, M. (2005). Economic Globalization and the Welfare State in Affluent Democracies, 1975-2001. *American Sociological Review*, 70(6), 921-948.

Castells, M. (1998). *The Information Age: Economy, Society and Culture: The End of Millennium*. Oxford: Blackwell.

Deacon, B. (1997). *Global Social Policy: International Organisations and the Future of Welfare*. London: Sage

Dent, M. (2003). *Remodeling Hospitals and Health Professions in Europe: Medicine, Nursing and the State*. New York: Palgrave Macmillan

Esping-Andersen, G. (1997). *Welfare States in Transition: National Adaptations in Global Economies*. London: Sage.

Fairclough, N. (2004). *Analyzing Discourse. Textual Analysis for Social Research*. Taylor & Francis e-Library. Digital book edition. (First published 2003 by London and New York: Routledge).

Freidson, E. 2001. *Professionalism: The Third Logic*. Cambridge: Polity Press.

Goodson, I. & Lindblad, S. Eds. (2008). *Cross-professional Studies on Nursing and Teaching in Europe*. Deliverable 6 in the EU Sixth Framework Programme Project Professional Knowledge in Education and Health: Restructuring Work and Life between the State and the Citizens in Europe. http://www.profknow.net/files/results/WP6.pdf. [Accessed December 15, 2008].

Goodson I., & Norrie, C. Eds. (2005). *A Literature Review of Welfare State Restructuring in Education and Health Care in European Contexts: Implications for Teaching and Nursing Professions and Their Professional Knowledge*. Deliverable 1 in the EU Sixth Framework Programme Project Professional Knowledge in Education and Health: Restructuring Work and Life between the State and the Citizens in Europe. http://www.profknow.net/files/results/Literature_Review_WP1_EU.pdf. [Accessed June 2, 2008].

Hargreaves, A. (2005). Educational Change Takes Ages: Life, Career and Generational Factors in Teachers' Emotional Responses to Educational Change. *Teaching and Teacher Education*, 21(8), 967-983.

Kirpal, S. (2003). Nurses in Europe. *Work Identities of Nurses across 4 European Countries*. University of Bremen: Institute of Technology and Education. ITB – Forschungsberichte 07/2003. http://www.itb.uni-bremen.de/downloads/Publikationen/Forschungsberichte/FB_07_03.pdf. [Accessed June 3, 2008]

Koch, M. (2008). European Statehood in Transition. In J. Houtsonen & A. Antikainen (Eds.) *Symbolic Power in Cultural Context. Uncovering Social Reality*. Rotterdam/Taipe: Sense Publishers, 55-66.

Koch, M. (2006). *Roads to Post-Fordism. Labour Markets and Social Structures in Europe*. Aldershot: Ashgate.

Kosonen, T. & Houtsonen J. Eds. (2007). *European Nurses' Life and Work under Restructuring: Professional Experiences, Knowledge and Expertise in Changing Context*. Deliverable 5 in the EU Sixth Framework Programme Project Professional Knowledge in Education and Health: Restructuring Work and Life between the State and the Citizens in Europe. http://www.profknow.net/files/results/D05_European_Nurses_Life_and_Work_under_Restructuring.pdf. [Accessed June 3, 2008].

Lindblad, S. & Popkewitz, T. S. (2003). Comparative Ethnography: Fabricating the New Millenium and Its Exclusions. In D. Beach, T. Gordon & E. Lahelma. (Eds.). *Democratic Education. Ethnographic Challenges*. London: Tufnell Press, 10-23.

Mills, M., Blossfeld, H.-B., Buchholz, S., Hofäcker, D., Bernardi, F., Hofmeister, H. (2008). Conversing Divergencies? An International Comparison of the Impact of Globalization on Industrial Relations and Employment Careers. *International Sociology*, 24(4), 561-595.

Mills, M. & van de Bunt, G. G. & de Bruijn, J. (2006). Comparative Research. Persistent Problems and Promising Solutions. *International Sociology*, 21(5), 619-631.

Mishra, R. (1999). *Globalization and the Welfare State*. Cheltenham: Edward Elgar.

Nermo, M. 2000. Models of Cross-national Variation in Occupational Sex Segregation. *European Societies*, 2(3), 295-333.

Rafferty, A. M. (1996). *The Politics of Nursing Knowledge*. London: Routledge.

Ragin, C. (1987). *The Comparative Method: Moving Beyond Qualitative and Quantitative Strategies*. Berkeley: University of California Press.

Sohlberg, P. et al. Eds. (2007). *Professional Expertise under Re-structuring: Comparative Studies of Education and Health Care. The Survey Study*. Deliverable 3 in the EU Sixth Framework Programme Project Professional Knowledge in Education and Health: Restructuring Work and Life between the State and the Citizens in Europe.

http://www.profknow.net/files/results/WP3_Final_report.pdf [Accessed February 11, 2009]

Weber, M. (1978). *Economy and Society. An Outline of Interpretive Sociology*. Vols 1 and 2. Berkeley: University of California Press.

DENNIS BEACH

THE SOCIALISATION AND COMMERCIALISATION OF HEALTH PROFESSIONS IN EUROPE

INTRODUCTION

This chapter is based on reading of a broad cross-section of investigations of restructuring in the service sector in Europe, particularly in education and health (e.g. Freidson 2001; Dent 2003; Edwards & Usher 2002; Robertson et al. 2002; Gordon 2005; Scott 2004; Sen 2005; Mahony & Hextall 2000; Jones 2005; Bernstein 2000; Lundahl 2002a, 2002b; Roussakis 1995; Beach, J. 2003; Woodward 1997; Warne & McAndrew 2004; Petronikolos 2003; Moutsios 2003; Nelson & Gordon 2004; Grollios 1999; Zambeta 2002a, 2002b, 2004 and Kazamias et al. 2002). However, it is focussing in particular on recently produced work package documents in PROFKNOW –project. (www.proknow.net; Beach 2005; Goodson & Norrie 2005; Kosonen & Houtsonen 2007). This research has highlighted several processes to be prevailent in each national case; managerialisation, de-regulation, de-centralisation and rationalisation through standardisation. Professional administrative autonomy and legal recognition of professional status are seen too, as aspects of professionalisation. These general trends have different manifestations in each country. Specific cycles of public to private transformation in production relations in the health-care sector and a massive movement of nursing labour into the private health industry as commodified labour power is also important and the research has also suggested that State involvement has been important in these processes. Conversions have occurred very recently in some cases and sometimes in very concentrated forms in others.

The processes of conversion also seem to be expanding in scope with negative consequences for professionals, professional(s') knowledge, professional identities and commitments, nurse-patient relationships and (in particular) the health-care services available to and consumed by lower-class fractions of health service recipient-consumers. As Kosonen and Houtsonen expressed it in their summary to Kosonen and Houtsonen (2007, 9-10), "calls for economic accountability and efficiency and the rationalisation of administration" have accompanied "neo-liberal restructuring in the health-care sector in general" and the nursing professionals and their practices within this sector. These trends refract a little differently in each country but they are common developments nevertheless, as "the contracting model of employment begins to dominate (numerically, administratively and ideologically) over the service model... Hospital, clinics and the health-care system… is now driven by demands for

J. Houtsonen, G.-B. Wärvik (Eds.), European Nurses' Life and Work Under Restructuring pp. 15-28.

increasing cost-efficiency, throughput and results, accomplished through guidelines, standardisation, evaluation and (extrinsic) rewards. For practicing nurses these… factors mean a (more) precarious career and tight resources that contribute to increasing experiences of workload and haste, stress and exhaustion."

BRIEF SUMMARIES OF NATIONAL DEVELOPMENTS SINCE 1960

Portugal

Nunes (2003, 320-321, in Beach 2005) characterises four main landmarks in Portugal: the establishment of a single basic training level aimed at providing general health care (1974); the autonomy of the nursing schools previously under the dependence of hospitals, that now came under the control of qualified male and female nurses; the single career of nursing professionals where all know their job and to which all have access (1981), as well as the integration of nursing education in the national university education system (1988). These changes empowered nursing professionals, most of which became civil servants with higher wages and lower working hours. To enter nursing courses, applicants needed a high school degree (11th grade). This requirement level was set due to a high number of applicants and led to the full integration of nursing education in technical college education in 1988. The nursing course (three years) conferred a bachelor's degree that enabled the first master's courses in nursing education to subsequently develop and a new career progression based on grades (grade 1 nurse, grade 2 nurse, specialist nurse, head nurse, supervisor and nurse technician made possible also by national regulations).

Since 1995 there has been a growth in regulation, by the consolidation of nursing education at the higher education level and by the introduction of new management models in hospitals and primary health care centres. This regulation clarified concepts and practices and characterised nursing care and practice as autonomous. It also functioned as a national regulation tool for the profession. In 1998 the Nursing Professionals' Association (Ordem dos Enfermeiros) was established, allowing the government to recognise nurses' aptitude for defining practice as well as for adopting an ethical and a disciplinary code that would assure the quality of nursing care.

From 2002 onwards, as a result of studies which indicated the need for more flexible management to increase effectiveness and also of some previous successful experiences, new hospitals were organised as limited companies or as private-public companies adopting management principles closer to private enterprise. That is, in this context, the State has the concession of the hospitals and primary health care centres and supervises the system. These hospitals remain within the National Health Service and its performance inspection system. The recent establishment of the Health Care Regulation Entity (Entidade Reguladora da Saúde) illustrates the State's growing role as a regulator in the field.

Ireland

The trends mentioned in the introduction of increasing professionalisation and increasing privatisation is clearly manifested in the Irish case studies in PROFKNOW. The evidence of increasing professionalism is suggested by the introduction of codes of conduct and the development of professional organisations as well as a move to academic education in 2002 with a degree programme being offered for the first time. This produced a substantial increase in theory and a proliferation of specialist posts and post-graduate courses. Privatisation in health services seems to have a detrimental effect on several aspects of quality of care. Professional education and training has also changed location over the past 40 years and a number of strategies will have to be introduced or enhanced before the expressed commitment to professionalisation can be realised.

The work of nurses is also undergoing change driven by the demand for a cost-effective, consumer-responsive service in line with the changing demographic and epidemiological profile of the Irish population. Marketisation is a fast developing phenomenon and has influenced the re-positioning of professional boundaries for nurses. This is evidenced by the introduction of the Scope of Nursing and Midwifery Practice Framework and changing forms of expenditure on in-service training since 1999 at a time of rapid socio-economic change. Moreover, the public health service is almost constantly reported as being in crisis with many patients awaiting hospital beds and waiting lists for surgery that are frequently reported as being unduly long. Private medical care is increasing and Irish nurses seek better career opportunities and remuneration in the U.S and the Middle East in particular. As a consequence in recent years, the Public Health service in Ireland has had to import nurses from the Philippines. It is amid this turbulence, which is set to continue, that new roles, responsibilities and career trajectories are being forged and the knowledge base of nurses is being re-formed.

Spain

The General Council of Nursing (Consejo General de Enfermería – CGE) is the organisation dedicated to the definition of the nursing profession and the defence of nurses' interests and health promotion. Its trajectory is therefore essential to understanding professionalisation, which is actually said to date back to the 16th century. Nursing was then defined as the 'art of healing', a conception that was in force until mid 20th century when the first Professional Associations (Colegios Profesionales) were born and the first attempts to develop a General Statute for nurses were made. It was not until 1978 that such Statutes were passed (Royal Decree 1856/1978), wherewithal nursing became a profession with a university degree recognized by the State and a Professional Association – the Organización Colegial de Enfermería (Consejo General de Enfermería, 2005). The Statutes were modified in 1993 (Royal Decree 306/1993) and completely redone in 2001 (Royal Decree 1231/2001) and 2003 (Act 44/2003). The nursing mission is now "to give

health attention to individuals, families and communities during the full life cycle" through interventions based upon "scientific, humanistic and ethical principles". In 2003, the long pending definition of health professions was also accomplished (Act 44/2003).

The last milestone in the recent constitution of nursing on a legal level has been the Basic Statute (Estatuto Marco) from 2003 (55/2003 Act). The process of negotiation of the Statute was long and difficult. First drafts faced great resistance in several arenas of discussion. One of them was the competences: all nationalist parties considered that the legislation violated competence. Another issue was mobility. The plan to introduce the possibility of compulsory mobility was resisted and finally changed. In its final shape the Act conceives mobility as a right, not a duty, and it is rendered as voluntary. But again, some exceptions are allowed. The Act was finally passed with the abstention of the Socialist Party.

The altruist definition of the profession continues to be frequent ('help others'). But an economic discourse is emergent and nursing is now becoming more and more regarded as just another job, a way of making a living. This makes the social relations of production into a key question for nurses' professional practices. The dominant form of nursing is now a formally specialised hospital-based practice within a complex organizational system. A tight educational network allows for cohesion, a permanent flux of knowledge, collaboration, and the development of a professional identity. The trends of privatisation and professionalisation are again clearly visible in the Spanish case study materials (see particularly Beach 2005; Kosonen & Houtsonen 2007).

Greece

The welfare state deficit is evident in the low level of professional development in nursing till the 1970s in Greece, which was upgraded in the 1980s, the period of welfare state expansion that developed new opportunities and jobs for nurses. The universities were then perceived as the key to social status and upward mobility for professions and professionals. However, welfare state restructuring has taken place since the 1990s and has impacted on the profession in different ways. The profession is becoming more stratified and this is reflected in its internal organisation. Even though the state sector is still the preferred employer for nurses, there has been a substantial increase in the privatisation of health services in recent years, with adverse effects on working conditions. Professional burn out is a particular problem. Tensions are evident among a globally inscribed representation of quality as efficiency and evidence based policy and practice on one hand, and equality of access and democratisation on the other.

Between 1945 and 1974 there was no formal training before entering the workforce, and only 2-3 years of informal training at work sites. The profession was dominated by a medical discourse and the needs of medical practitioners. Nurses were simple assistants for hospital ward work. Between 1974 and 1989 a 4-year initial training

was introduced along with Erasmus Programs and other EU collaborative efforts. No training was offered at work sites but the profession was still medically dominated. In 1983 Law 1404/1983 was passed regarding Technological Educational Institutions and the National Health Care System (1983) and in 1990 the first admissions to a Nursing degree programme at Athens University were made (1990). New curricula were established in 1995 and 1996. These were revised in 2003 and post graduate training was set up. Programmes for in-service training were also initiated in some hospitals. Autonomy of nursing professionals gradually emerged with the help of EU Directives of 1992, 1997, 1998 and the WHO directive 1992.

Finland

Up to the 1970s, policy issues that concerned the health care delivery system were mainly about building the service system and improving accessibility. The introduction of the Primary Health Care Act at the beginning of the 1970s formed the basis of the health care system and health policy. In the 1990s, developments in health care were influenced by 'external' circumstances: severe economic recession, the 1993 state subsidy reform, Finland's membership of the EU and socio-economic turbulence in neighbouring countries. However, a broad policy of preventive health care was still being pursued, whereby health was taken into consideration in all aspects of public decision-making. This extended developments from the mid-1960s onwards that put priority on health care and also shifted emphasis towards outpatient and primary care. In 1972 came the Primary Health Care Act and establishment of health centres together with the introduction of the national planning system. In the 1980s the health care and social services were incorporated into the same national planning and financing system and the Hospital Act in 1990 led to increasing deregulation and emphasis on municipal autonomy. About 10% of nurses now work in the private sector (Sohlberg et al. article in this book). Private hospitals and specialist practices are found in the bigger cities, particularly in Helsinki. Moreover, the number of for-profit nursing homes has been increasing in the past few years.

Estimations of the impact of restructuring on the nursing profession in Finland are vague. What is clear is that centralised steering was drastically reduced in the 1990s and the local administration's decision-making powers were increased. The development has led to a situation where the position and importance of evaluation has been strengthened. Evaluation is closely linked to evidence based practice, current care guidelines and health technology assessment at the national level. The cost-efficiency of the system is monitored carefully and the outputs of different hospital districts are publicised. Also apparent is that the education of nurses has moved from nursing colleges to the higher education sector, in the regional polytechnics 1990s. The duration of education has lengthened to three and a half years, and nursing science has been developed and established as an essential content of professional education. International standards have also been introduced. Postgraduate studies at the level of Master's and Doctorate Degrees are offered at

some university faculties leading to administrative and teaching positions. Nurses have gained a stronger professional position in terms of education, knowledge and health care administration through their labour unions.

Sweden

Health care is often depicted as an organisation comprising three levels; primary care, county hospitals and larger region hospitals. Privatisation and market mechanisms have been introduced recently. At the same time as the state has parted with key economic governance tools in relation to detailed control of the municipalities. The 1990s is considered to be a period of extensive change in this respect in time with an economic crisis that reached its climax in 1992-1994 at the end of a short period of conservative government. However, the 1990s also witnessed substantial demographic changes as well as entry into the European Union in 1995.

Some key reforms are as follows. In the 1970s the so called 'Seven Crowns' reform was implemented. The reform stated that the patients would no longer pay directly to the doctor for outpatient care, but a fee of seven crowns to the hospital. This meant also that no private practice was to be carried out within the walls of public hospitals. In 1972 the county councils took over the district medical officers from the State and in 1982 a state commission (HS 90) pointed out the importance of preventive care. In 1992 The ÄDEL-reform was introduced. This reform implied that the care of long-term patients was transferred from county hospitals to the municipalities. This was an aspect of the decentralisation of the welfare state.

There were significant changes taking place in the beginning of the 21st century. For instance in 2003, an official report from a government committee (SOU 2003:23) stated that health care will never be able to fully meet all the needs of the citizens and that priorities will always exist. This report represents a retreat from the welfare state ambitions of full health care for each and every citizen according to need, established as an ambition in the "folk-home" project of the seventies. The committee also recommends that the development of health care should be steered toward open forms of care (i.e. in the home/family/community) and to preventive care. A variety of different private providers was also recommended but not for care that needs the heaviest technical and specialised resources of university or large county hospitals. These reforms have turned the emphasis of health care from inpatient to outpatient care, from hospital care to homecare and from a nationally owned and run public service to a more privatised organisation that emphasises and utilises the resources of (economic and rational) individuals and the family both 'practically' and discursively.

A Government Bill 1999/2000:149 presented an analysis of results of health care restructuring during the 1990s. The Bill explicitly gives the patients a more active position through an aim to further mobilise the patients' own resources. Patient involvement is not only for the benefit of the patient. On the contrary, the health care is outlined as dependent on patient involvement as a means to handle

increasing demands. Patients are to contribute to the coordination of their own care and also influence its organisation and methods. Recent evaluations also suggest that municipal primary health care is an unattractive work place where access to doctors, nurses, assistant nurses, and rehabilitation staff is becoming increasingly limited. New personnel are constantly recruited. Long-term sick leave and early retirement is more common than 10 or 15 years ago.

England

Restructuring in England has had profound effects on the nursing profession, not the least in terms of objectification processes that have developed from the 1980s onwards in connection with an intensified economic management that has penetrated deep into the health-care sector. There is now a huge emphasis on target setting and auditing, with associated bureaucracy and paperwork in the NHS and the formation of 'new knowledge regimes' based on health economics, health services research and outcomes research. This form of audit culture started in the USA in the 1970s and it has reached levels of development in the UK that are not yet approached in any other European country. Its effects on the profession (professional esteem and self-esteem, professional identity, stress and burn out, biomedicalization of knowledge and the use of probabilistic knowledge to improve clinical performance) are the replacement of individual professional knowledge as the foundation for clinical decision-making and they seem to have been mainly negative. Other aspects are evidence based medicine (EBM), clinical practice guidelines (CPG) and health technology assessments (HTA). They have led to excessive paperwork that is said to be for quality assurance but which also plays a role in a culture of surveillance and blame.

In the UK it was suggested that nurses were once able to think of themselves as people within a vocational service, with a job for life, but this has changed considerably. The descriptions in PROFKNOW now suggest that nurses think in terms of nursing as commoditised labour; just a(nother) job. Moreover, new ways of thinking about illness and health have emerged. Illness, disease, disability, infirmity and care are new market opportunities and this significantly alters relationships between clients and nurses and the character of nursing work. Increased stress levels have accompanied these developments. A study by Britain's health and safety watchdog has found that nursing, dominated by women, was one of the most stressful of all professions. The Health and Safety Executive found that more than three in 10 suffered stress at work (Heath and Safety Executive, 2003/2004) and that people between the age of 41 and 50 were more stressed than older or young workers. Nursing has become increasingly marketised, individualistic and infused with an ideology of choice. Recruitment deficits, levels of stress and burn out and job dissatisfaction have intensified as has overseas recruitment. There have been no significant developments in education and training however in the past twenty years.

DIFFERENCES AND SIMILARITIES ACROSS NATIONAL DEVELOPMENTS

Descriptions like the above; which roughly refer to two kinds of development, professional knowledge and status on the one hand and privatisation and commercialisation on the other; may be taken to correct earlier suspicions from statistical survey research that there are different developmental trajectories in national health services and supply for the North, South and Offshore states in Europe, which are also said to be highly dependent on national contexts and politics. Because what is suggested in descriptions like the above, and even more clearly with regard to the national case-studies they are based on, is – as also Kosonen and Houtsonen (2007) suggest – that there are significant challenges to this idea of national independence and variation, particularly with regard to the new millennium. What is suggested is that there are significant consistencies (loss of autonomy, privatisation, commercialisation, fragmented professionalism, audit thinking, stress, burnout, retention difficulties, overseas' recruitment) with respect to present trajectories of change (http://www.profknow.net/fs-results.html).

Differences in health service structure and supply and the nursing labour process in Europe are particularly minimal from the turn of the new millennium and especially in the last three to five years, where nursing has developed as a practice that is increasingly organised and run according to basically equivalent neo-liberal standards, economic thinking and 'a Schumpeterian', market oriented open economy (Beach 2008, 2009). The EU innovation program, and its main development plan, the Lisbon Strategy, are based on such ideas, which imply a shift from national to post-national and networked modes of labour production and a new common concept of health care policy and practice within which national policy and internal professional demands are subordinated to the demands of an expanding European (or even global) market that employs economic competitiveness and increased privatisation as a motor of development. This kind of 'restructuring' not only changes the concept of welfare, it has a dramatic impact on working life as well, since it genuinely alters the definition of worker- and recipient rights and practices. New factors of professional culture are nursing for sale, illness as a market opportunity, flexi-labour and multi-tasking (Beach 2003; Gordon 2005; Scott 2004; Kosonen & Houtsonen 2007).

These things are common developments that are addressed in the current volume as are issues that are also identified in Kosonen and Houtsonen's work (2007), such as increased experiences of work overload and under-resourcing, increasing use of temporary contracts and stressful working conditions, reduced senses of autonomy, tightened levels of formal control and changing qualities in the characteristics of patient-nurse relationships. The following list summarises some of the main noted common developments.

- Decentralisation
- Development of an emphatic discourse of privatisation and marketisation (habituation)
- Company formation in the health-care sector
- Conversion of public health services to private interests
- Business takeover of ancillary services, health supply and nursing supply
- The creation of quasi markets for consolidating the processes of privatisation
- Authorities forming agencies for contracting out services to private suppliers
- Costs of administration shifted from ownership to managing and monitoring
- Increased costs from franchise effects (un/under-employment) on public employees
- The increased objectification of labour and increases in the value form of labour
- A dissemination of a view of patients as economically rational, self-interested consumers
- A redefinition of health-access and democracy in terms of consumer choice
- An increased objectification of health/ill-health and care-labour as factors of production
- Increased class differences in terms of supply and consumption
- Increased class inequalities in work conditions, contracts and education consumption
- Increases in judgement of performances according to consumer values
- Standardisation of care-assessment for comparison of performances

Restructuring in the health sector in Europe thus has a consistent pattern according to the PROFKNOW research packages and the chapters in the present book, even though this pattern is not exactly replicated in each country. Moreover, England is far ahead of the other partners in terms of the race toward full commoditisation. A number of things have been suggested as particularly noteworthy. These include:

- Three processes of development are ubiquitous instruments of change in relation to the restructuring of the nursing profession in Europe over the last 50 years (Beach 2009). These are (i) the socialisation and (ii and iii) the habituation and subsequent commercialisation of (professional) nursing.
- That in each nation involved in the research nursing and health are talked about and packaged (both in service supply and in education supply) very differently today than for 15 to 30 years ago.
- That we are also talking very much more similarly between national systems today than we were then and are also packaging health and health service training in similar ways as ‘travelling discourses and packages’.
- That education and training supply and development are rarely driven from centralist state monopolies, in for instance the universities or State bureaucracy, as in the past. Systems, people and events “outside” the (original) system seem to be pushing for changes far more than changes are pushed for and motivated from within.

- That the common trajectory of development through socialisation of labour power, habituation within the profession and its systems of education and training and a subsequent commercialisation and an influx of neo-liberal principles of governance is somewhat offset (time-wise) between nation states.
- That socialisation has principally almost always taken place in each country as a precursor to habituation and commercialisation, which can thus also be seen to prey on and socially, economically and discursively exploit publicly developed infrastructures, institutions, workers and practices (also Beach 2009).

This list is very different to the common description of the material contribution of commercialisation and competition to the development of an effective service infrastructure.

QUESTIONS OF GLOBAL CLASS AND GENDER

Within the chapters of the present book and in previous research accounts from PROFKNOW (see e.g. Goodson & Norrie 2005; Kosonen and Houtsonen 2007; Beach 2005, 2009) the issue of class differences has been suggested to be highly significant in the provision and consumption of health-care and nursing services. These class differences are historical and contemporary. They derive from issues of (economic) power and control through which the upper-classes in Europe have historically always been able to obtain private access to nursing and care from sources outside the home, such that the creation of common services there, in some kind of public model, represents a de-commercialisation of services rather than a movement from kinship systems to 'external' ones, as with respect to the economically less well off citizens. For them the creation of a common public system represents an externalisation of the domestic labour of women and the incorporation of this (predominantly female) labour power into public organisations (Beach 2009). However, what is also noticeable now is that neither process was ever fully secured in Europe (there were always parallel class-related processes of care going on) and that both developments are now anyway also being reversed in ways that show how global capitalism is significantly altering the relationships established in recent eras between social classes and the state in respect of nursing services. Interests of class parity have receded significantly as a direct result of neo-liberal insurgences into the service economy and have led to exacerbations of existing class differences (also Rosskam 2006; Beach 2005, 2009). In Europe today, although all sectors of the population avail themselves of an NHS (or its service-society equivalent) in a common 'national health interest', this is always supplemented from 'outside' the NHS and in two very different ways from for people of different class backgrounds. The level of supplement is on the increase, often encouraged by changes in taxation laws in member countries to stimulate individual responsibility and the private markets.

There are some important points here regarding the ways the welfare state national health concept in Europe should be politically, historically and economically

understood. For what is suggested is that despite national rhetoric in some countries (such as Sweden) there has never been of 'one kind of nursing' in 'one system of health care' for all members of 'one classless state' equally. Nursing has always been (and is once again becoming increasingly) divided as a resource that is unevenly available and unequally distributed according to variables of social class, even though it must also be admitted that – through the stronger political organisation of the working classes, women and ethnic groups – a better material standard of nursing and health for all has been won in some countries (notably again Sweden) through struggles against the capitalist class and their political allies by trades-unionist and other folk-movements (Beach 2005, 2009).

Another key emergent point in the PROFKNOW -project that has not yet been discussed here is that nursing is principally, historically and contemporaneously, a female occupation that is increasingly recruiting candidates from lower- and lower-middle class backgrounds, or from low-GDP countries (http://www.profknow.net/fs-results.html). The processes of transformation that have taken place in respect of the formation of labour and the development of a (now increasingly commercialised) professional labour in the health sector are therefore principally referring to the successive movement of women's domestic labour. This movement of labour has been first from (lower-middle and working-class) homes to the public sector and then from public service to increasingly commercialised organisations as an aspect of economic labour power, where price-pressing (economic competition) and recruitment problems have now also led to increasing overseas recruitment as well. These are important points. They suggest that forms of (free) labour have been shifted into the broader arena of the production economy in a way that has implied both a feminisation of the economy and a potential ethical transformation of specific labour relationships on global-economic terms. This is usually said to have led to an increased freedom and independence for women. But this idea can be challenged through a material analysis of actual developments in economic terms, because this 'freedom' – if that is what it really is – has only been won at a significant cost.

Put very briefly the feminisation of the economy through expanded nursing labour has coincided with a less openly discussed general 'dampening' effect on real income levels for the lower and lower-middle economic portions in Western societies, with severe consequences for equality and liberty generally (Hill 2006), for which, with few exceptions, the social and material-economic situation of nurses is an example. Real hourly income levels for individual nurses have dropped significantly in the past forty years in Western Europe, on average, with the result that in general nurses have become low paid workers in relation to years of education and training who are incapable of supporting themselves and their families on a single income. Rather than the often spoken on freedom implied by liberal feminists through the explosion of women's paid labour in the public health sector, the development of this sector has actually primarily resulted in a more effective extraction of surplus value from production that is now, post-commercialisation, being openly exploited for economic profit.

CONCLUSIONS

The terms productive and useful labour, as discussed for instance in Marxist literature, become important concepts in respect of what has been suggested to have occurred with respect to nursing (as labour and as professional work) in the present chapter. In Marxist use these concepts differ from the understanding generally employed in bourgeois economic theory. Useful labour is a purposive activity which meets a human need. Productive labour is labour that is productive principally in the economic sense; i.e. labour that directly creates new economic value and 'makes' a profit for someone. It is the unpaid part of labour as measured in proportion to the total capital invested in production that is expropriated from workers and distributed by various means among the capitalist class. This is what I am suggesting has happened concretely, practically and theoretically with respect to nursing in the last 50 years.

However, there are also other implications. One of these concerns the role of the welfare state in the processes of capitalisation I am suggesting have occurred. Instead of being seen as 'the opposite' of private production and as an example of the redistribution of surplus value the welfare state becomes seen in this chapter as an intermediary in the creation of commodified labour power and the capitalist processes of conversion of 'other' value forms into objectively economic forms that are accumulated by capitalists through the sale and purchase of this labour and its products (also Beach 2009). In this sense, the expansion of the welfare state becomes an important intermediary in the growth of capitalism rather than something opposing and resistant to capital and commercialisation is no longer seen as a process that contradicts previous (social democratic/welfare state) developments of services and service values. Instead it utilises these developments directly in processes of accumulation of economic capital.

However, as also expressed in Beach (2009), this doesn't mean that the commercialisation and liberalisation of nursing doesn't embody an important political retreat from previous efforts to establish some form of social equality and democracy through health care provision. Indeed it does. The neo-liberal restructuring of nursing is dependent on an established material, social and knowledge infra-structure comprising people, places, tools, artefacts, technologies and practices. This infra-structure has often been supplied (and/or is currently being supplied) by public efforts using public resources to produce useful labour. It is now being 'privatised', liberalised and exploited for profit by private enterprises. The pathway of 'development' has been more compressed into the latter portion of the most recent decades in some countries (e.g. Greece and Spain), where socialisation and commercialisation are in fact operating almost in parallel, whilst in others (e.g. UK) developments have been spread over a longer time period and have progressed further.

REFERENCES

Beach, D. Ed. (2005). *Work-package 2: Welfare State Restructuring in Education and Health Care: Implications for the Teaching and Nursing Professions and their Professional Knowledge*. Second deliverable in the EU sixth framework project Professional Knowledge in Education and Health: Restructuring work and life between the State and the citizens in Europe. [http://www.profknow.net/fs-results.html]

Beach, D. (2008). The Changing the Relations between Education Professionals, the State and Citizen Consumers in Europe: Rethinking Restructuring as Capitalisation, *European Educational Research Journal*, 7(2), 195-207.

Beach, D. (2009). Socialisation and Commercialisation in the Restructuring of Education and Health Professions in Europe: Questions of Global Class and Gender, *Current Sociology*, (in press).

Beach, J. (2003). Professional Knowledge and Its Impact on Nursing Practice. *Nurse Education in Practice*, 2, 80-86.

Bernstein, B. (2000). *Pedagogy, Symbolic Control and Identity: Theory, Research and Critique*. Maryland: Rowman and Littlefield.

Dent, M. (2003). *Remodelling Hospitals and Health Professions in Europe: Medicine, Nursing and the State*. London: Palgrave Macmillan.

Edwards, R. & Usher, R. (2002). *Globalisation and Pedagogy: Space, Place and Identity*. London: Routledge.

Freidson, E. (2001). *Professionalism: The Third Logic*. Cambridge: Polity Press.

Goodson, I. & Norrie, C. Eds. (2005). *Work-package 1: A Literature Review of Welfare State Restructuring in Education and Health Care in European Contexts.* First deliverable in the EU sixth framework project Professional Knowledge in Education and Health: Restructuring work and life between the State and the citizens in Europe. [http://www.profknow.net/fs-results.html]

Gordon, S. (2005). *Nursing Against the Odds: How Health-Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care*. New York: Cornell University Press.

Grollios, G. (1999). *Ideology, Pedagogy and Education Policy. Discourse and Practice of the European Programmes on Education*. Athens: Gutenberg.

Hill, D. (2006). Education services liberalisation. In E. Rosskam (Ed.) *Winners or Losers? Liberalizing Public Services*. Geneva: ILO.

Jones, K. (2005). Remaking Education in Western Europe. *European Educational Researcher Journal*, 4(3), 228 – 242.

Kazamias, A., Zambeta, E. & Karadjia, Ed. (2002) Greece: Educational Reform 2000 - Toward a Paideia of Open Orisons - The Modern Greek Sisyphus. In S. Linblad and T. S. Popkewitz (Eds.) *Education Governance and Social Integration and Exclusion: Studies in the Powers of Reason and the Reasons of Power*. Uppsala Reports on Education 39: Uppsala University.

Kosonen, T. & Houtsonen, J. Eds. (2007). *European Nurses' Work and Life under Restructuring: Professional Experiences, Knowledge and Expertise in Changing Contexts*. Deliverable in the EU sixth framework project Professional Knowledge in Education and Health: Restructuring work and life between the State and the citizens in Europe. [http://www.profknow.net/fs-results.html]

Lundahl, L. (2002a). Sweden: Decentralization, Deregulation, Quasi-markets – And then What? *Journal of Education Policy*, 17(6), 687-697.

Lundahl, L. (2002b). From Centralisation to Decentralisation: Governance of Education in Sweden. *European Educational Research Journal*, 1(4), 625-636.

Mahony, P. & Hextall, I. (2000). *Reconstructing Teaching: Standards, Performance and Accountability*. London: RoutledgeFalmer.

Moutsios, S. (2003). The Identity of the European Union and the European Pedagogic Identities, *Comparative and International Education Review*, 47(2), 62-94.

Nelson, S. & Gordon, S. (2004). The Rhetoric of Rupture: Nursing as a Practice with a History? Nurse Outlook, 52, 255-61.O.E.C.D. (2001). *Education at a Glance*. Paris: Organisation for Economic Co-operation and Development.

Petronikolos, L. (2003). European Identity and Citizenship Education. The Case of Greece, *Comparative and International Education Review*, 47(2), 95-126.

Robertson S., Bonal, X. & Dale, R. (2002). GATS and the Education Service Industry: The Politics of Scale and Global Territorisation, *Comparative Education Review*, 46, 472-96.

Rosskam, E. Ed. (2006) *Winners or Losers? Liberalizing Public Services.* Geneva: ILO.

Roussakis, Y. (1995). European Citizenship: a symbol and a process in the New Europe, a challenge for Greece. In A. Kazamias and M. Kassotakis (Eds.) *Greek Education. Perspectives of Restructuring and Modernisation*. Athens: Seirios.

Scott, A. (2004). The Nurse: Autonomous Professional or Subservient Worker. In W. E. Tadd (Ed.) *Ethical and Professional Issues in Nursing. Perspectives from Europe*. New York: Palgrave.

Sen, K. Ed. (2003). *Restructuring Health Services: Changing Contexts and Comparative Perspectives.* London: Zen Books.

Warne, T. & McAndrew, S. (2004). Mirror, Mirror on the Wall, Who is the Most Improved of All? *Journal of Nursing Management*, 12 (1), 131-136.

Woodward, V. M. (1997). Professional Caring: a Contradiction in Terms? *Journal of Advanced Nursing*, 26(6), 999-1004.

Zambeta, E. (2002a). Europeanisation and the Emergence of Entrepreneurial Culture in Greek Education: Reflections from Education Policy, *Education and Social Justice* 4(2), 15-23.

Zambeta, E. (2002b). Greece: Modernisation and Control in Teacher Education. In E. Thomas (Ed.) *World Yearbook of Education 2002. Teacher Education: Dilemmas and Prospects.* London: Kogan Page.

Zambeta, E. (2004). Greek Education 1980-2001: From the Demand for Democratisation to the Promotion of Entrepreneurship. In Sakis-Karagiorgas-Foundation (Ed.) *Social Change in Contemporary Greece (1980-2001)*. Athens: Sakis Karagiorgas Foundation.