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Health Care Work in Europe - Introduction to the Workshop

The service sector in general and health care and health industry in particular in the last decades have been the motors of structural change of European economies. This certainly goes for Scandinavia, but continental Europe is catching up[1].They have left their imprint even on 'old industrial areas' such as Northrhine-Westphalia, where meanwhile almost 2 mio. people work in the health industry; 180.000 of these jobs have been created only during the last decade. This may justify to speak of the health industry as a "job machine" and the "hidden champion" of structural change.

Bottle Neck Working Conditions.

Yet there is some water in the wine. The job machine splutters, not due to demand but due to supply shortages. Staff is lacking in more or less all health service professions, doctors as well as nurses and medical and non-medical assistants. So far there are no comprehensive and comparative studies about reasons and causes[2], but a few are evident: there is a lack of junior staff, limited income perspectives and above all unattractive working conditions.

One aspect should be noted beforehand: the demographical factor. Populations are shrinking all over Europe, with the consequence of lower numbers of potential recruits for a job in the health and related services. However, politics apparently prefers not to acknowledge this simple fact and to include it into respective considerations for reform or reconstruction of health services.

A few data from Germany, which is the third biggest spender on health (behind the USA and Switzerland) among the OECD countries, may highlight this situation[3]. The largest groups of employees in the health sector are nurses and doctors. Between 1991 and 1999 demand for nursing training and education programmes has diminished by 6.5%, while the number of offered trainee places has gone down only by 1.7%. An almost dramatic situation is to be stated for auxiliary nurses, where interest in training has gone down by 55.6%!

Concerning doctors, the situation is a little bit different. Interest in the respective university courses is relatively constant over time, but large numbers of the graduated young doctors afterwards do not show up in the medical professions, be it in clinics or practices. Between 1991 and 2000 the share of under 35-year-old

1 cf. Smith 2002, table 2, p.288
2 for a comprehensive international data set see OECD Health Data 2003; for a comparative study on employment see Schneider et al. 2002, who analyse employment differences in relation to organisational and financial structures of health systems
3 data and information are taken from Dülberg/Hilbert/Fretschner 2002, p.42 ff.; see also Statistisches Bundesamt 2002

doctors has dwindled down from 27.4% to 18.8%, which indicates a process of geriatrisation of this core staff group.

In contrast to these two medical staff groups in the remaining health service professions or professions close to medical and care services (dieticians, physiotherapists, laboratory assisants, health protecting professions etc.) the situation is somewhat better. Qualification and training capacities during the 90ies have gone up by 12.6%, but still this growth cannot compensate for the general loss.

A second reason certainly are income perspectives, even in a high-wage country like Germany. On the whole employees in the health services in West-Germany have lower incomes than their counterparts in the industrial part of the economy, and also average growth rates are smaller. In the period of 1986 to 1995 hospital doctors had an average yearly growth in income of 3.3%, and nurses/doctor's assistants of 4.3%; a comparable employee to the latter enjoyed a growth rate of also 4.3%, but starting from a roughly 35% higher basis (1995). If you correct for an exceptional rise in 1990 and 1991 the yearly growth in income for a hospital doctor is reduced to 2.6%, and 3.7% for a nurse and 3.8% for the fictitious employee in industry. In east Germany the situation is different: it is devastating.

A third and probably the trigger reason is working conditions. Working conditions in the core health services are almost traditionally bad. Long and irregular working times, shift work, and high physical and mental strains are the rule and lead to broadly spread burn-out-symptoms, above-average fluctuation and job leavers[4]. The ranking of reasons suggested here, with working conditions on top, can be underpinned by a survey conducted on behalf of IAT[5], which displayed that in spite of the working conditions employees in the health services evaluated participation, cooperation, room for initiative and work place autonomy higher than the average of all service sector employees. In other words: employees work with high intrinsic motivation, but they are defeated by external conditions.

"Customer orientation" is a strategy, where these factors cumulate and make for a subjective feeling of exploitation. Measures to improve information, consultation and support for patients/"customers" have been and are at the core of endeavours to enhance efficiency and productivity of clinics. The findings of a benchmarking study[6], which comprised 30 clinics as well as 7370 patient and 6827 employee questionnaires (valid questionnaires) showed a remarkable contrast between patient/customer satisfaction and employee satisfaction: where patient/customer satisfaction was high, employee satisfaction was low. Main causes for employee dissatisfaction were found in a lack of coordination and support by superiors and management as well as in uncertainties about the policy and strategy of the institution. This leads to a number of interfaces and communication problems with the large set of instances involved in a given case; employees are able to cope with these problems, however, at the price of additional working time needed for search and finishing activities, which adds to the already existing intensity and strains of work.

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4 for an in-depth-analysis of working conditions in the nursing sector (in Germany) see DAK-BGW 2000; also ver.di 2003 and Büssing/Glaser 2003

5 cf. Born 2000, special analysis for IAT

6 Bandemer/Born/Middendorf/Scharfenorth 2003

This little encouraging situation may, by and large, be assumed for continental Europe and the UK, while concerning working conditions Scandinavia is somewhat ahead. Still, also Scandinavia suffers from an even more severe lack of staff in this sector, which hampers economic development as well as novel forms of health service governance and organisational and workplace innovation.

However, innovation and the opening of new perspectives for the health sector is also hindered by short-sighted political reactions to general budgetary strains. The common answer in most European countries is plain cost-cutting, without sufficiently acknowledging that the health sector for long has become a driver of value added and employment nor of the precarious relation between value added and employment[7] and the role of work organisation for enhancing efficiency both on operational and the system level. Some of these issues and aspects are explored in the papers presented in this workshop.

From compliance to innovation: clinical re-organisation as a reflexive process

The above notes are mainly based on German observations, but with their opening statement that "surprisingly work organisation achieves little recognition in the NHS policy agenda" *Rosemary Exton* and *Peter Totterdill* confirm this as a core issue. In their case study *"Partnership, Governance and Innovation at Nottingham City Hospital"* they point out the consequences of implicit but nevertheless widespread neo-Tayloristic thinking especially in clinical middle management, which fosters a mechanistic view of organisational behaviour, the perpetuation of traditional forms of work organisation and hierarchy, and, if it comes to change, top-down target setting. Given the present turbulent environment for social policies in general and a growing pressure for enhancing efficiency in particular, and confronted with recruitment problems and employees' dissatisfaction with working conditions, clinics, which are governed the traditional way, soon find themselves in the "quality assurance without quality improvement trap". As a way out *Exton and Totterdill* outline a new initiative "Improving Working Lives" (IWL) introduced by the NHS and evaluate the first outcomes using the case of Nottingham City Hospital.

Somehow the authors' findings remind of the situation as we know it from change processes in industry: the new initiative is welcomed as a new policy, but the point is rather how to implement and embed it across the organisation and to ensure participation across all hierarchical layers in order to not only recognise but make best use of the "valuable resource represented by the skills and knowledge of the employees". Yet here, the conclusion in the Nottingham case goes, both management *and* unions still have a way to go to leave their well-trodden paths and to recognise and accept their specific role and competencies in such a complex change process. The question is, what happens until they have found their way?

This is the starting point in the contribution by *Palle Banke* and *Annemarie Holsbo*, who, nomen est omen?, head their paper *"Can apnea be avoided when developing*

[7] an exception is the report of the German Council of Experts for Concerted Action in Public Health of 1996 and the report of the German Council of Experts for Economic Development of 2001, which analyse the health sector as a branch of the service industry with considerable multiplyer and value adding effects. However, these insights have not yet translated into strategies of restructuring and reform of the German health system.

work organisation in hospitals?" Again, the four change processes they observe and analyse take place against a background of increasing pressure for more efficiency, to be interpreted as lower costs, and decreasing supply of labour, to be interpreted as "voting by feet" on the working conditions. Patient processes and interdisciplinary coordination were identified as the key variables to be improved in order to achieve better quality and efficiency which would benefit both patients, the hospital enterprise/management and employees.

Similar to the Nottingham case, interdisciplinarity and cooperation primarily presents a challenge to hierarchy. Mutual recognition of roles and functions, and in consequence information and knowledge sharing as a prerequisite for cooperation to the benefit of work processes and coordination to the benefit of patients in the first instance appears to be a matter of perception. "Each staff group has and has had its eyes on the process and their special challenges. ... So, although in most of the projects the doctors have been invited to participate, they have typically not come to feel committed to the matter or to have the opportunity to think of themselves as a part of the basis for changes." So the actual change process is more about the reconciliation of perceptions of roles, work assignments, qualifications and competencies between staff groups. The danger of "apnea" comes in, when these processes take too long and what is so special about the project gets lost in everyday routine[8].

Perspectives for further research

What then are the conclusions for further research in "Health&Care Work in Europe"?

The starting point clearly is the hypothesis, which is also sketched out in the presented papers of this workshop, that personnel development is one of the crucial bottlenecks of further economic and social development of health and care as service to the public as well as a branch of the service industry. To do something in this direction is necessary and the more urgent since

- there is an ideological warfare about the dismantling of the welfare state which necessarily will lead to the erosion of the financial structures of health and care
- the internationalisation of national health and care services is progressing (international suppliers, labour migration) despite the needs and demands of an ageing population
- there is simply a lack of knowledge about intelligent solutions to comparable problems.

What is needed is a Europe wide "Programme for Modern Work in Health and Care in Europe", based on systematic comparative analysis and design of model solutions. Methodologically from the research side an action research based approach would be appropriate, and from the side of actual change strategy and implementation an inclusive participative approach would have to be applied. Exemplary themes following the discussions in the workshop and the conference might be

[8] "apnea" means "respiratory standstill"

- cross-enterprise quality management and benchmarking methods, procedures and projects to improve efficiency and quality of health & care in respective institutions (public and private)
- further development and dissemination of work related and support technologies (e.g. documentation systems)
- linking-up of care (outpatient, inpatient) with neighbouring services, to avoid ghettoisation, and also to support work load balancing by rotation and exchange possibilities for personnel

More specifically work related issues are:

- qualification and training schemes for management personnel in organisation and management (leadership, mediation, personnel policies), applied technology and marketing
- modern design of working time schemes and flexibilisation; usage/application of job rotation schemes
- development of assessment schemes to identify required future personality profiles of personnel in health & care
- solutions for child care of employees' children during working hours to improve the employability (and recruitment) of employees
- development of subcontracted labour schemes to better balance cases of sick leave, to balance work overload and to give room for rotation and for further training and qualification
- mobilisation, recruitment and qualification of personnel from other branches (loosing employment); recruitment and integration of foreign staff

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