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Overview Paper

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1 INTRODUCTION

This overview paper has been prepared to highlight the key trends and issues presented in the country reports submitted by the national nursing associations for the 8th International Council of Nurses (ICN) Workforce Forum in Reykjavik, Iceland. The objectives of the forum are to:

- Stimulate thinking, enhance learning and develop proactive strategies in addressing workplace concerns of nurses;
- Identify trends in nurses' remuneration and negotiation frameworks;
- Determine nurses' short, medium and long-term priorities in the area of socio-economic welfare; and
- Support international partnerships for the advancement of nurses and nursing.

The national nursing associations were requested to prepare written reports on the seven themes corresponding to the forum agenda topics. These themes are SEW nurse-related developments, Nursing workforce data, Negotiations, Workforce utilisation, Pension/retirement, Political activism and SEW, and Professional status of the nurse. This paper is organised according to the themes and highlights issues that appear in different country reports.

At the time of preparation of this overview paper, country reports had been received from the Icelandic Nurses Association (INA), the Canadian Nurses Association (CNA) and the Canadian Federation of Nurses Unions (CFNU), the Danish Nurses' Organization (DNO), the German Nurses Association (DBfK), the Norwegian Nurses Association (NNA), the Swedish Association of Health Professionals (SAHP), the American Nurses Association (ANA) and the Royal College of Nursing of the United Kingdom (RCN). Not all associations commented on all agenda topics.

2 SEW NURSE-RELATED DEVELOPMENTS

2.1 Pay

Most of the reports acknowledged that equal pay is central to further development of nursing. The value of any profession is echoed in its pay and its comparability to the pay of other professions with equal education and responsibility. Based on this it seems, according to the reports that the value of nursing ranks lower than the value of comparative professions in many of the countries. A central question is "why do the rules of marketing society not apply to nursing"? Why are the salaries of nurses not increasing more, given the situation of a chronic shortage of nurses in most of the countries that attend the workshop? It seems that the answers to these questions are to be found in the monopoly of the state and municipalities as the major employers of nurses, and in central agreements.

Some countries, mostly Scandinavian, have been trying new models for agreement over the past few years. In these models, pay is decided in a more decentralised fashion and individual nurses have the opportunity to negotiate at the workplace.

These models are constantly being developed, but are already giving good results. In Iceland the rise in pay was over 50% after the new wage system was installed. The ANA report brings to attention the unequal rise in pay during the working life span of nurses. The difference in salary is greater between graduates and a nurse who has been practicing five years, than between the five-year-nurse versus a nurse who has been practicing for 15 – 20 years. It seems that professional age (years of service) does not result in higher pay.

2.2 Working conditions

The problems related to shortage of nurses and increased workload, are still at the centre of the national reports. The countries report increased overtime and mandatory overtime. The consequences are increased absence due to illness (Sweden, Canada), less work satisfaction (Denmark) and regrets in choosing nursing as a profession (Norway).

In Iceland, the health care environment has been infected with constant lack of funding (or reorganising services according to monetary restraints) that influence the working environment of most health care professionals.

Sweden reports that the greatest increase in ill health is found among women in the public sector and among nurses specifically, due to factors like high workload, staff shortages, poor management and conflicts. There is also increased demand from life in general. In their report, they warn against women “adapting themselves to death”, and address the important issue of the psychosocial working environment.

In Canada, the CAN has written a position statement on the *Quality professional practice environments for registered nurses* that addresses the environment needed for nurses to thrive in, professionally and individually.

3 NURSING AND WORKFORCE DATA

3.1 Supply and demand trends

We do not detect great changes in supply and demand among the countries since our meeting in 2001. Most of the countries are facing or will face nursing shortages. The extent and timing of acute shortage differs since the assumptions behind projection models differ between countries.

Country reports mention the following as contributing factors to the shortage: less graduates from nursing schools, greater job opportunities for nurses outside the traditional working environment, aging workforce and decline in relative earnings. The only country that reports a surplus of nurses based on official figures is Germany. However, the DBfK questions the accuracy of the data since nurses have to report themselves unemployed during maternity leave and in other situations. Also a survey of several thousand managers of nursing institutions in Germany reported shortages of nurses in all settings, in hospitals, community services and nursing homes. One of the findings from this survey was that the qualifications of applicants to nursing positions were diminishing. The country reports do not generally discuss the qualifications of applicants to nursing schools. Presently, young people do not seem interested in

pursuing a nursing career. That is an issue that is being discussed at length in Iceland, since we not only wish to increase the number of applicants to nursing, but we want quality students to compete for the places available.

Each country is dealing with the shortage differently. In Germany, the official position is that there is no shortage, therefore there is no official recruitment policy. On the contrary, foreign EU nurses are denied working permits due to the surplus of nurses in Germany.

The UK government has taken the nursing shortage seriously enough to work with the RCN to develop and put in place a range of measures to increase supply. These include:

- High profile advertising campaigns to encourage health service careers;
- Expanding the number of nursing student places available in higher education and increasing student bursaries and grants;
- ‘Back to nursing’ initiatives, including increased funding for courses and payments for individuals;
- Delayed and phased retirement initiatives;
- Establishing a national NHS owned agency for nursing staff;
- Improved child care provision;
- Promoting flexible working;
- Targeted policies and payments in areas where the cost of living is high.

Other countries report similar strategies. In Iceland, a successful image campaign aimed at recruiting students to the university nursing programs resulted in over 100% more applicants to the programs this Fall. In Denmark, work is ongoing regarding retainment of nurses that have reached pension age, by offering them bonuses and a different pay system. In Norway, hospital owners are spending a considerable amount on overtime, recruitment from abroad and agency nursing in order to meet the shortage of nurses. The Canadian report stresses the importance of policy making at a governmental level regarding nursing shortage.

The ANA reports what they call the “forces of magnetism” or recognised elements, i.e., “force,” which contribute to a satisfied nursing workforce that must be incorporated into the culture of hospitals and health systems. In 1983, the American Academy of Nursing (AAN) established a Task Force on Nursing Practice in Hospitals and ultimately published a critical document, *Magnet Hospitals Attraction and Retention of Professional Nurses*. The focus of this work was to identify the organisational elements that seem to be associated with success in recruiting and retaining professional nurses. Numerous government reports and commissions had already talked about high vacancy rates and the associated problems of the nursing shortage, but there had been no evaluation of hospitals that were succeeding in recruiting and retaining nurses. Following intensive group interviews of administration and staff nurses employed in hospitals nominated as excellent workplaces, the Task Force identified fourteen “forces of magnetism” that reflect a culture that allows for nursing excellence. According to the ANA report, the average vacancy rate for registered nurses is currently 13 % in hospitals, and 18.4% in nursing

homes. However, the turnover rates for registered nurses are estimated to be 20.5% in hospitals and 55.5% in nursing homes. Interestingly those hospitals and health systems that have been designated as “Magnet” facilities have an average vacancy rate of 8.19% and an average turnover rate of 11.57%.

4 NEGOTIATIONS

4.1 Collective/individual bargaining

There are different models noted in the reports regarding collective versus individual bargaining. It seems that the associations are willing to move towards more individual or decentralised bargaining. However, this is taking a long time due to different societal factors.

In Germany, the DBfK is a member of a union that negotiates for nurses. The union negotiates for the whole public sector collectively each year. In Germany, there have been public events highlighting the serious working conditions of nurses. However, the union is not willing to negotiate better salaries or working conditions for nurses, due to the influence it would have on the negotiations for the whole public sector.

In the UK, nurses’ pay is determined by an independent review party, leaving little opportunity for individual negotiations. Presently, there are ongoing negotiations in the UK addressing a completely new bargaining structure and approach to pay progression. These negotiations are to be finished in 2002 and implemented in 2003.

In both Iceland and Sweden, there is collective and individual bargaining. The process towards individual bargaining seems to be further advanced in Sweden than in Iceland. In Iceland, there is a structured centralised bargaining that the individualised bargaining builds upon. In Sweden, the centralised part is less structured and they are focusing on an individualised pay system based on professional qualifications of an individual nurse.

In Norway, the NNA went through turmoil in negotiations this year. The NNA started the year with a strike to force the employers to the negotiating table. The strike was stopped after six weeks without immediate results. However, the NNA reported good results in the main pay settlement in May 2002. The negotiations in Norway are similar to Iceland with central and individual bargaining.

In Denmark, there is central and decentralised bargaining. Individual nurses do not bargain for themselves. Central bargaining is in the hands of the DNO with decentralised bargaining being in the hands of local branches and their chairpersons.

The USA is different from Europe. Only 21.5% of nurses there are covered by union contracts, which must indicate that the majority of nurses do their own contracting.

4.2 New contract language

In the UK, the RCN and other NHS trade unions have for over two years been involved in detailed negotiations over a new pay and grading system. This system comprises a new bargaining structure, an entirely new job evaluation system, a new approach to pay progression and more. The new system is expected to be implemented in phases, starting at the beginning of 2003.

In Denmark, the principal contents of the basic agreement include: a yearly regulation of salaries, including an adjustment of the salaries in relation to the development in the private market; the 6th week of paid vacation; improved pension schemes; and improved conditions for the workplace representatives. Every employee must have a plan for professional development and the individual salary development must be evaluated every year.

The principal contents of the special agreement were a further improvement of the fulfilment of the 1997 commitment containing a higher salary grade for most of the leading nurses, and a rise of the bonus for qualifications to nurses without management responsibilities after working 8 or 12 years.

In Norway, in Spring 2002, the NNA negotiated main pay settlements in the largest wage agreement areas. In Norway, there seems to be a trend towards employers wanting to gradually abolish social rights that have been accrued over a period of many years – such as service pension, holiday schemes and working regulations. Employers in Iceland have embarked on the same route.

In Canada, nurses want issues of mandatory overtime, workload, nurse-patient ratios and whistleblower protection addressed. CFNU has embarked on a process of determining long-term bargaining goals. These goals will be nationally agreed upon and incorporated into bargaining agendas at the provincial level.

These goals include:

- Developing structures that support nurses working to their full scope of practice.
- Improving employer paid short-term and long-term education leave provisions.
- Providing employer paid in-service education programs.
- Employment security.
- Giving more decision-making authority to front-line nurses and meaningful participation in decisions impacting their working lives (i.e. calling in additional staff or closing beds).
- Strengthening professional responsibility clauses (clauses which provide for documentation of situations which compromise safety and quality of the practice environment and provide mechanisms for resolving the issues. Saskatchewan Union of Nurses has achieved that decision from the Independent Assessment Committee, which will be binding as related to nursing issues).
- Reserved acts in the collective agreements to prevent the replacement of nursing positions with non-nursing.

- Establishing more regular full-time permanent nursing positions/increasing core staffing i.e. creation of permanent resource nurses for front-line nursing staff.
- Accommodation of disabled nurses – collaborative return to work programs for nurses who have been off work due to illness or injury.
- Provisions that support and/or enhance family supportive workplaces – fully paid maternity/adoptive leave, family leave, on-site day care and elder care provisions.

4.3 Workplace representative: selection, function, training

Workplace representatives are elected in every employer area in the Nordic countries, where the workplace has at least five employees (Iceland and Denmark). The RCN has also a network of representatives who are elected. These representatives work by legislation and are often protected by law for such things as dismissal and working conditions. The number of working representatives ranges from 2,5% of the registered nurses in Denmark to 4,5% in Iceland and 5,4% in Norway.

RCN representatives carry out the role of steward and safety representatives. The importance of workplace representatives is clear in the Nordic countries where they often join in local negotiations (wages, working hours etc.) and in other matters related to the members' working area. Workplace representatives work as a liaison between members and institutions on one hand, and members and associations on the other. They have the best overview of the situation in the workplace to look after the employees' wages and conditions of employment and can inform the association if it is important to act further on certain matters. Workplace representatives seek support and information from the association. Therefore, it is very important for them to have a good relationship with their association.

Members' primary contact to the association is often through the representatives. Once accredited the representatives receive training in the basic rights and obligations of working life and the relevant legislation and agreement. The basic training supports political learning and understanding, which is a foundation for action, dialogue, and attitudes towards political matters relevant for trade union, along with the functions and importance of union representatives.

Both in Denmark and Norway many of the representatives are given full or partial paid leave by their employer to perform their duties. In Iceland the representatives have the right to use 7 days a year to attend meetings or seminars paid by the employer.

NNA representatives are offered handbooks and modules totalling 47 hours and more advanced training which consists of negotiation courses, and relevant current political issues each year. DNO offers an 11-day seminar of basic training for their representatives within the first year. DNO also offers several free seminars, which are all adapted to the representatives' local and personal needs. Once a year all workplace representatives meet with DNO's leadership in order to discuss subjects of current interest. INA gives courses once or twice a year for their workplace representatives. RCN undertakes a basic training programme that is currently given by face-to-face training but will include distance learning in the future. The knowledge and skills acquired are used in the workplace on behalf of members to represent them collectively.

5 WORKFORCE UTILISATION: UPDATE

5.1 Models, including workload measurement and 5.2. Collective agreement ratios (e.g. RN/patient)

The country reports mention various types of models in use. SAHP refers to specific instruments, one that is used by intensive care units and another used to measure various types of care units for the elderly.

In Sweden, a project started in 2001 aims to develop basic principles for accessibility to information on performance, costs and quality.

In the UK health service there are no collective agreements on staffing, staff/patient or staff/population ratios. Moreover, the government is also in the process of introducing a new 'integrated' approach to health workforce planning, with renewed emphasis on changing traditional professional boundaries and introducing multi-disciplinary approaches.

The Canadian report recognises the importance of developing accurate workload measurement systems. However, they have not been able to work on that issue.

In Denmark no agreements have been made concerning collective agreement ratios between the number of registered nurses and patients. However, to every 1000 inhabitants there are about five nurses employed in the hospitals. The same number for doctors and other health care personnel in the hospitals is approximately 2 and 2 1/2.

In Iceland, no legislature has been approved for work measurement or nurse/patient ratio. However, the Directorate of Health in Iceland has published guidelines regarding minimal number of nurses per patient in nursing homes.

In Norway no criteria have been established centrally for the number of nurses per patient. Some of NNAs professional groups and some workplaces are working to establish standard ratios, but the NNA as a whole has not taken part in this work.

In Germany several methods of calculating nursing workload and patient needs are being tested (FIM, PLAISIR, LEP). The Canadian PLAISIR is very likely to be introduced for all nursing homes in Germany.

The ANA reports that in the USA there are currently several efforts underway to understand the impact of the organisation of work and work schedules on workers. They mention a report released by the U.S. National Institute for Occupational Safety and Health (NIOSH), *The Changing Organization of Work and the Safety and Health of Working People: knowledge gaps and research directions*, that identifies a comprehensive research agenda for investigating and reducing occupational safety and health risks associated with the changing organisation of work. Only in California has a proposed minimum nurse-staffing ratio been legislated. Other state legislatures are also considering legislation that would mandate specific nurse to patient ratios.

Six states (Florida, Iowa, Kentucky, Missouri, New Jersey, and Rhode Island) are considering legislation similar to that of California that would require nurse to patient ratios in hospitals and/or other health care facilities. The state of Virginia is considering ratios for the operating room. Six states (Minnesota, Mississippi, New York, Ohio, South Carolina and West Virginia) are considering nurse to pupil ratios in schools.

6 PENSION/RETIREMENT

6.1 Benefits

Pension rights are well covered by legislation in the Nordic countries. It differs between Norway, Iceland, Sweden and Denmark regarding the specifics of the pension systems (i.e. how much the employer pays into the pension fund and the percentage of salary the pension is) and the age at which nurses are entitled to retire. More or less the monthly pension is a certain percent of the monthly salary of nurses. The pension lasts until the death of the individual, whether it is 2 years or 30 years after retirement.

In Iceland and Denmark, nurses can retire at the early age of 60, in Sweden at the age of 61 and in Norway from the age of 62. Early retirement requires some special conditions in all of the countries. The usual age is 65 – 67 years.

In Germany, there are no special arrangements for pension schemes for nurses. Their workforce is young and pension does not seem to be high on their agenda.

In the UK, all NHS staff are entitled to contribute to the NHS Pension Scheme. The scheme provides an annual pension based on 1/80th of the final year's pay for each year of scheme membership and a tax-free lump sum worth three times the amount of the yearly pension. The usual time of retirement from the NHS is 60 years.

In the USA, pension rights are bargained for. There is not much information available to describe the type of pension and retirement benefits that nurses currently have. A 1999 survey done by RN magazine of 2558 registered nurses showed that 89% of full time registered nurses and 72% of part time nurses had some type of retirement plan. However, the ANA mentions a lot of questions that need to be answered regarding the retirement plans of American nurses.

In Canada, unionised nurses are covered by employer, or government, sponsored pension plans. In many provinces, nurses have been successful in negotiating that the pension plans be jointly trusted, ensuring equal labour and management representation on decision-making bodies with respect to administration and enhancement of pension benefits. As a result, many plan surpluses are now spent in improving benefit provisions as compared to past practices of pension contribution holidays.



6.2 Strategy to retain older nurse in practice

There are indications in some of the reports (Denmark, Germany) that government is tightening the rules regarding early retirement.

The main strategies to retain older nurses are to provide flexibility around their retirement. Ideas that are presented in the reports relate to working part-time and pensionated part-time; gradual withdrawal from paid work; receiving a bonus if you work past your retirement age, a release from working night shifts after a certain age (55 in Denmark and Iceland); and more flexibility in work schedules .

In Denmark, there is an alternative for employees in a leading position: instead of early retirement they can change the job into a non-leading position, but with the same salary as in the leading position.

7 *POLITICAL ACTIVISM AND SEW*

7.1 Channels

The major channels that the larger countries have are lobbying and political activism. This involves, according to the ANA report, contacting a member of Congress about a legislative issue; becoming involved in a political campaign; organizing other nurses to become involved in a campaign; giving a financial contribution to a political action committee or directly to a campaign; organizing public campaigns and profiling towards politicians and the public, or running for political office.

The ANA has a long history in these issues. In their report, they state: “ANA believes that political involvement is necessary to support its efforts to enact federal legislation. This process has often been described as three legs to a stool - the stool will not stand if one of the legs is missing.

The first leg is making political endorsements.

The second leg is an active grassroots program that involves local registered nurses in the races for their members of Congress.

The third leg is a lobbying program that educates legislators about ANA issues related to nursing, health, labour and a myriad of other concerns like human rights, immigration, and trade. Lobbying is really the art of persuasion with the goal being to convince a legislator to support a position on an issue or to follow a particular course of action. While ANA has paid lobbyists on staff, the act of lobbying is done by ANA members every day through writing letters to their member of Congress, making telephone calls, and making personal visits to the legislator’s offices in the district or in Washington, D.C.”

The major channel for Canada and the UK is also lobbying. In the Scandinavian countries, the nurses organisations are usually a member of a larger union and through these they exert considerable influence and are asked to comment on bills and

resolutions presented at Parliament. Additionally they lobby heavily at a political and public level.

Due to their size, it is easier for countries like Iceland to contact and influence the policy making in the country. Also the INA has relatively easy access to the Minister of Health and Social Welfare. The INA is asked to comment on every parliamentary bill and resolution presented in the Parliament that relate to health care. Through participation in the Association of Academics the INA has an opportunity to comment on workforce related bills. At all times, a member of the INA sits on the board of the Association of Academics. Presently, the member is a vice-president of the association.

In Germany, the DBfK is in continuous contact with all relevant groups and institutions that have an impact on nursing and working conditions of nurses. DBfK is involved in all discussions about new legislation. They have developed a ten-year program focusing on the further development and improvement of nursing services. Through a reform of nursing education the DBfK hopes to raise the image of nursing in society.

7.2 Members training programmes and materials

Many of the country reports did not address this issue. Those who did emphasised the importance of organised regular meetings with representatives of different chapters within the nursing organisation, building networks, providing learning material for nurses and developing programs for nurses that assist them in learning how to assert themselves and negotiate individually or how to lobby for their own course.

8 PROFESSIONAL STATUS OF THE NURSE

8.1 Arguments in support

Education

From the reports of the national nursing organisations it can be read that the educational status of nurses in the country is of importance in enhancing their professional status. Some of the countries like Iceland have legally defined a BSc degree the minimal education for entry into practice. Others, like Germany, are aiming towards that.

A growing number of nurses with Masters and Doctorates also seem to influence the status according to the national nursing organisations. It is also the opinion of Iceland that having a nursing department within traditional academic universities is of importance

Research

A few of the country reports mention the importance of nursing research being conducted, implemented and introduced to the public.

Legal status

It is vital that the authority and power base of nurses be grounded in national law for them to be influential and hold professional status.

Trustworthiness

DBfK mentioned in their report that in a recent survey in Germany nurses were found to be the trustworthiest profession. This was not mentioned in other country reports but should be considered in relation to professional status.

8.2 Update: Cost-effectiveness research

Many countries did not mention cost effectiveness research. Only ANA addressed this issue at length. In the USA, there is a strong growing interest in articulating the economic value of nursing. They refer to two studies that have done an excellent job at beginning to define the costs savings associated with having a sufficient number of nurses providing care. The cost savings are usually associated with the prevention of a negative patient outcome.