ENGLISH NURSE EDUCATION
AND
NATIONAL HEALTH SERVICE REFORM

1985 – 1997

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ENGLISH NURSE EDUCATION
AND
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I certify that this work has not been accepted in substance for any degree, and is not concurrently submitted for any degree other than that of Doctor of Philosophy (PhD) of the University of Greenwich.

I also declare that this work is the result of my own investigations except where otherwise stated.
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ENGLISH NURSE EDUCATION AND NATIONAL HEALTH SERVICE REFORM
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A EXPOSITION

I ABSTRACT

Between 1993 and 2002, I have produced 32 publications representing a coherent body of work examining the development and implementation of nurse education policy in England between 1985 and 1997. A selection of 16 of these are included in this submission. Some of the others are cited mainly for the purpose of demonstrating the impact of my work.

The work examines questions about the fundamental characteristics of the arrangements for nurse education, how and why these changed as they did over the period in question and the implications of these changes for stake-holders and participants. Answering these questions has required a wide-ranging multi-disciplinary research programme theoretically informed by a number of disciplines including education, economics, policy studies and sociology, and including empirical work and archive-based primary source analysis.

During the period in question, profound changes occurred in the arrangements for English nurse education. These are explained in policy terms, with reference to the intersection of two distinct but overlapping policy processes, firstly a professional project and secondly, the radical reform of the NHS under the Thatcher government. Examination of the implications of these issues is wide in scope, ranging from the position of individual nurses and nurse trainers, through college management, qualitative and quantitative workforce supply issues through to life-long learning barriers in the NHS.

International comparative studies provide explanatory insights and the impact of the work is demonstrated through numerous citations among other forms of recognition.
2 THE PROGRAMME OF RESEARCH

The political and policy context for nursing and nursing education over the period in question was established exclusively by Conservative governments. Due to economic crises during the 1970s, which eroded the government’s ability to deliver on its social welfare obligations, the State’s role in offering such provision was increasingly questioned. Earlier consensus was broken by the emergence of a ‘new Conservatism’ or ‘new right’ under the leadership of Margaret Thatcher. A central feature of this new Conservatism was its hostility to the post-war expansion of state welfare which was expressed in commitments to ‘Roll back the State’ and give pre-eminence to market forces, thereby allowing individuals to take responsibility for their own lives. While it is the case that Thatcher governments during this period did not, in the event, dismantle the Welfare State, they did succeed in implementing a major reconstruction of provision. This included profound internal reorganisation of State services. As a consequence, in both education and health, new patterns of control were introduced in which market forces were an explicit component (Loney et al 1991).

The Education Reform Act of 1988 brought about fundamental changes in the way that educational services were supplied in England. The general aim of the reforms was to introduce a more competitive market approach to the allocation of resources in the education system, and to increase parental choice as a factor in children’s schooling (Glennister 1981). With formula funding replacing historical grants, it was supposed that improvement in education quality would result from a market system in which quality was financially rewarded by virtue of improved student recruitment. Therefore, newly empowered school managers would act to ensure that the choices of newly empowered parents resulted in their institutions growing at the expense of less effective schools.

The 1988 Act stimulated research activity much of which was theoretical or philosophical in nature. Furthermore, the empirical research that was conducted tended to be specifically focussed on either consumer choices, provider responses or the resulting market effects. In one case however, these three elements of the education market were linked in a research programme which sought to understand
and theorise the education market and its origins as a whole (Ball 1990, Gerwitz et al 1995).

The second major reconstruction of welfare services was initiated by the NHS and Community Care Act of 1990. In that year the waiting list for NHS care passed the one million mark, this despite over £21.5billion of public expenditure. Given growing criticism, action on the NHS was inevitable and the solutions, as with education, reflected the new right politics of the market. As with education also, the reforms involved decentralisation of control to more autonomous providers, along with elements of ‘consumer choice’ (this time mediated through GPs and Health Authorities). Some detail of these reforms is given later, as they provide a necessary context for understanding the arrangements for nurse education. For the moment it is sufficient to note that, around this time also, a market for nurse education began to emerge.

Being one of the first to recognise the implications of the market for nurse education, it struck me that as a study in education policy development, nurse education might provide an interesting parallel to studies into the mainstream education market, particularly if like Gerwitz and Ball, I researched the market as a whole, rather than just particular components of it. I therefore embarked on a research programme whose coherence derives in part from the recurring theme of the market.

The sequence of publications presented here constitutes a selection from 32 published pieces generated on the basis of a research programme of about 10 years duration. The work is essentially a study in the field of education policy covering both policy formulation and implementation. The focus of the work is a particular case of professional education (nurse education in England). This area has certain merits as a subject for policy research in that the occupational group is clearly defined, as indeed is the activity of professional education: nurse education being regulated and funded through statutory institutions distinct from other education and training operations.

In addition, as a research subject, nurse education has other positive features both generally and in relation to the particular period studied. In the first place the supply of nurses carries high political stakes for any government, not only due to the crucial
position of nurses in terms of the NHS workforce, but also because of the caring nature of their work and its positive impact on public regard for the occupation. Secondly, the period 1985 – 1997 for reasons explained above, saw seismic shifts in both nurse education itself and the industry in which nurses work.

The focus of the work submitted then is on the development and implementation of policy with regard to nurse education in England between the formation of the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) in 1985, and the end of Conservative Government in 1997. At the beginning of this period, in 1985, a hierarchically organised National Health Service included regional and district health authorities. District health authorities (DHAs) contained facilities both for delivery of health care services (including hospitals) and the training of nurses. At that time 179 schools of nursing were located within DHAs and in many respects, education and clinical practice were closely linked: schools of nursing were financed through the District which employed all their staff; directors of nurse education were responsible to nursing service managers; and nursing trainees were employees of the District. All funding for the training of nurses was routed through the District although some originated with the English National Board for nursing, midwifery and health-visiting (ENB). The approval of education and training institutions and programmes was the responsibility of the ENB. (These arrangements are described in more detail in publications 1,3 and 9.)

By mid 1996 none of the 179 schools of nursing remained. Without exception, they had been acquired by mainstream higher education institutions (HEIs). This process had involved considerable rationalisation such that by 1995, 87 HEIs were providing the training previously delivered by the 179 District schools. Essentially a large number of relatively small NHS schools of nursing with structural and intimate links to health services had been replaced by a relatively small number of much larger providers outside the NHS.

Moreover, as a consequence of the NHS and Community Care Act of 1990, the introduction of the so-called internal market had caused the splitting of DHAs into distinct purchaser and provider units – restructured health authorities taking the former role and NHS Trusts emerging as the latter. Therefore, by 1997 the DHAs
which had owned both schools and hospitals owned neither. In the context of these changes the funding of schools of nursing shifted initially to Regional Health Authorities (which were subsequently abolished as a consequence of the Jenkins Review) and ultimately to consortia, consisting largely of employers (NHS Trusts).

Fundamental changes also occurred during this time in relation to nursing. In 1985 two levels of nurse existed both within the NHS and in terms of training programmes: the first level 'registered' nurse and the second level ‘enrolled’ nurse. By 1997, enrolled nurse training had stopped completely and whilst level 2 nurses remained residually working within the NHS, they were no longer part of the long-term future of nursing services. Even for registered nurse training, changes occurred which were highly significant. In 1989, new ‘Project 2000’ programmes, leading to higher education awards commenced, eventually replacing altogether the earlier form of registered nurse training.

The publications submitted here represent an attempt to analyse, explain and, on the basis of such, influence aspects of policy and policy implementation over this period. Collectively, the papers address three distinct but related questions regarding the development of nurse education.

1. What were the underlying policy priorities and processes which explain why the new arrangements emerged?

This work was rooted theoretically in terms of the sociology of professions and in policy theory, and was based in the main on analysis of contemporary policy documents either published or held within the archives of the UKCC.

2. What were the fundamental characteristics of the arrangements for nurse education which developed and how did they differ from the traditional arrangements?

The arrangements for nurse education are analysed in terms of market theory and examined empirically in relation to ideologies and values held on both supply and demand sides.
What were the implications of the new arrangements for nurse education for educators, employers and nurses?

Taking as its starting point the outcomes of work in relation to question 2, this work again combines theoretical analysis with empirical investigation to establish the nature of effective performance within the new market context.

While answering these questions has required a multi-disciplinary programme (drawing on sociology, economics and policy studies) the work as a whole should nevertheless be seen as an educational research programme and it is in the field of education policy (with special reference to health care education) that most of the original contributions lie.

In selecting 16 out of a total of 32 publications, I have sought to illustrate the coherence of the work as a whole, show the progression from earlier to later work and while doing this, where possible, to avoid overlap. While this exposition focusses on the 16 primary submitted works, I nevertheless sometimes refer to one of the additional papers which are not included in this file. I do this when they are relevant in terms of the literature review aspects of the exposition, or because they establish my personal intellectual priority over the work, or because they have enhanced the impact of my research. When I do refer to such papers they are referenced in the conventional way eg Francis and Humphreys (1998) and detailed in the reference section 7 along with all other cited authors. In contrast, the 16 formally submitted publications are not included in the normal reference section but are listed separately in Part C, where each is given a number from 1 –16. For brevity and convenience, these papers are referred to in the exposition by their number eg (see publication 16) or just (16). The actual publication can then be easily found in the file by locating the corresponding numbered tab.

3 THE EMERGENCE OF THE MARKET

3.1 The Professional Agenda

In July 1985 a new statutory structure for nursing was inaugurated which had at its heart a single UK central council, whose principal function was to establish and improve standards of professional conduct and training. That organisation, the United Kingdom Central Council
for Nursing, Midwifery and Health Visiting (UKCC) had been conceived by a government appointed committee, whose terms of reference required it to “review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role” (Briggs 1972). Commenting on the wide range of bodies concerned with nursing and midwifery, the committee sought to rationalise and unify these occupations through a statutory administrative structure which avoided fragmentation and overlap. In fact although this new statutory structure also included four national boards (for England, Wales, Scotland and Northern Ireland) to arrange and co-ordinate the provision of training, these five new statutory bodies together, did indeed constitute a less fragmented dispensation, by virtue of the fact that the national boards were required by the Nurses, Midwives and Health Visitors Act of 1979, to discharge their functions subject to, and in accordance with, the rules of the new Central Council. I have argued that the creation of the UKCC marked the beginning of a new phase in the professionalisation of nursing (15). Reflecting on its strategic objectives, UKCC gave high priority to a fundamental review of the educational foundation for nursing (UKCC 1986a). In 1984 this review commenced under the title ‘Project 2000’.

Within the scope of this study, a developing momentum for change in nurse education was first formally manifest in the Judge Report, commissioned by the Royal College of Nursing (RCN) and published in 1985 (RCN 1985). The report identified a high wastage rate among student nurses and linked this to a shortage of suitable tutors in clinical areas and the utilisation of trainee nurses as a necessary component of the clinical workforce. The report recommended the uncoupling of education from direct control by service such that student nurses would be freed from the obligations of work in order to concentrate on learning.

These and other RCN recommendations were symptomatic of a growing concern about the ability of nurse education to produce a sufficient supply of qualified nurses with the increasingly sophisticated skills necessary to operate in modern acute and community nursing environments. Moreover some issues raised in the Judge Report constituted long-standing problems with corresponding recommendations going back sometimes as far as the establishment of the National Health Service in 1948. (Briggs 1972, Wood 1947).
In the same year the English National Board (ENB) produced a consultation paper (ENB 1985) and in 1986, the UKCC itself published its “Project 2000” proposals (UKCC 1986a). These various reports, although containing significant differences of emphasis and detail agreed on some important points of principle. Demographic change and long standing educational problems were identified which were considered to threaten the supply of qualified nurses. Consequently questions were raised regarding the capability of pre-service education and training programmes to recruit and train a sufficient supply of nurses with the necessary skills to operate effectively within increasingly demanding clinical environments. In the context of these concerns a 20% wastage rate was generally considered to derive at least in part from what was referred to on occasions as the “abuse” of student nurses (UKCC 1986a) through their utilisation as a necessary part of the clinical workforce.

At that time, two levels of nurse delivered patient care. The first level “registered” nurse and the second level “enrolled” nurse. Virtually all nurse training was delivered within the National Health Service (NHS) at a level equating to non-advanced further education (Goodwin and Bosanquet, 1986). In May 1988, at the RCN Annual Congress, John Moore (then Secretary of State for Health) announced the Government’s broad acceptance of the Project 2000 proposals. As a consequence of that decision, 100% of initial training is now categorised as higher education and delivered outside the NHS in Higher Education Institutions and in due course, all nursing will be delivered by a single grade of registered nurse. These and other consequences of Project 2000 make the period since 1984, one of the most significant periods of change in the long history of nursing and nurse education and arguably, one of the most important since the campaign for nurse registration around the turn of the 20th century (see Dingwall et al, 1988, Rafferty, 1996).

3.2 Professions and Professionalisation

The status of professions is based on claims by relatively exclusive occupational groups, to practice on a foundation of specialised knowledge normally acquired through advanced education and training. Often distinguishing themselves from other occupations by prestigious attributes such as integrity, strict ethics and high-level skills, the classic professions have been conceived as being at the forefront in the economic, welfare and technological development of society (Parsons 1963).
While something of this perspective is retained by the public at large, since the 1960's an alternative view has been elaborated by academics in which professionalism is seen as a strategy through which occupational groups seek to achieve monopoly in sectors of the labour market, and then use that monopoly to achieve high income, power and prestige. This view does not suppose that the individuals in the group are necessarily or even usually explicitly motivated by their own collective interests. Rather it is argued that the tenets of expert knowledge, altruism and concern for public welfare come to permeate the thinking of the group, forming an ideology which legitimises collective and exclusive material and social rewards, (reviewed by Johnson 1972). Commonly professions are established through both legalistic and credentialistic tactics, the former involving efforts to gain legal monopoly for the occupational group through state licensing, and the latter defining the group and restricting access to it through educational certification (Collins 1979).

This type of analysis has led to a more sceptical school of thought in relation to the professions but it is important not to over simplify the position. Although the policies of conservative governments over the period in question imply otherwise, the organisation of occupational groups is not of course necessarily seen as inherently problematic. Marx and Engels (1967) for example argued that the task of trades unions is to abolish workers competition, a point which emphasises that the organisation of labour must be a collective endeavour in order to be effective, as breakdown in solidarity on the supply side effectively erodes or destroys workers' power within the labour market.

A further aspect of professionalism is the control that professional groups exert over work itself. Since the client is supposedly ignorant relative to the professional, there is a sense in which entering into a relationship with a professional means entrusting one's interests to that person. On the basis of this notion it can be argued that to prevent such trust being misplaced or exploited, the professional must have autonomy, that is to say freedom from outside interference in exercising her or his expert knowledge in the interests of the client. Such "jurisdiction" over the occupational area has therefore been considered by Abbott (1988) as a defining feature of professionalism. The same broad argument provides justification both for the rejection of managerial intervention and the retention of control over the body of expert knowledge within the professional group.
However this traditional notion, in which specialist expertise is sometimes used to justify the assumption that only the professional can determine the real needs of the client, has been under attack from several directions. Growing questioning of the supremacy of technical and scientific knowledge, along with the growth of consumerism over the period in question, and a number of high profile misconduct cases, has contributed to the positioning by some of professional autonomy and self regulation as designed primarily to evade client, managerial and state control, thereby ensuring that the content and practice of professional services remains in line with the professions own predilections, rather than by what governments, employers, or citizens might actually want. (Harrison and Pollitt 1994). Therefore, the question of professional autonomy ultimately concerns control over work, meaning not only the practice of individual professionals, but also broader issues ranging from the nature of effective practice to the role of particular professions in relation to preferences and goals whose origins lie outside the professional group, such as with an employer, an industry, or the state.

Notwithstanding the above generalisations different occupational groups vary in the extent to which they have achieved the control of the market for services and the related benefits of status. A distinction has been made for example between the classic and established professions such as medicine and law, and the sub, pseudo, or semi-professions (Etzioni 1969) whose status, power and benefits are much more limited. Larson (1977) however through her conceptualisation of the process of professionalisation effectively dismantled any implication from an earlier sociology that there might be some feature of the classic professions which distinguishes them fundamentally from other occupations including the “semi professions”. Through her proposition that professionalisation as at base an attempt to translate one form of scare resource (specialist knowledge and skills) into another (social and economic rewards) she unifies semi and classic professions through a process – “the professional project” that they have broadly speaking in common. On this basis modern professionalisation theory is as relevant as an analytical basis for examining nursing as it is for medicine or law.

In achieving her model of the professional project Larson also opened the door to re-examination of the validity of medical and legal claims to special status, which in turn has helped to generate questioning of the underlying social values that contribute to the success of professional projects, especially from the feminist stand-point. Whilst as I show below
(and in my publications) Project 2000 is very much elucidated by the application of Larson type theory, in parallel to such work some have given attention to the argument for new professional values sets to replace (or "transcend") the conventional masculine stereotypes such as individual mastery, unilateralism and boundaries, with reflection, co-operation and inter-dependency (Davies 1996). More extensive considerations of relevant aspects of professionalisation theory can be found in publications 4, 5 and 15.

3.3 Nurse Education Outside the NHS

My interpretation of Project 2000 as the product of a professionally dominated policy process has been elucidated in terms of professionalisation theory as outlined above. In simple terms, upgrading the basic qualification of nurses brought them more clearly in line with the classic professions supposedly involved in high-level, theory-based practice. However, in addition to raising the qualifications of nurses, Project 2000 also structurally distanced training from DHA service priorities. In fact, by drawing in higher education institutions and ring-fenced government funding, Project 2000 considerably reduced the influence of DHA’s (including hospitals) in which the professional power base had earlier been eroded by the introduction of general managers (DHSS 1983, the Griffiths Report).

It is also noted in my work that prior to Project 2000, the development of nursing knowledge and theory was somewhat limited. The post-Project 2000 linking of nurse education into an extensive Higher Education system, with its tradition of research, had the potential for both accelerating the development of nursing knowledge while also limiting the influence of the NHS over the direction and character of its development. Therefore the agenda within Project 2000 was explained in terms both of increased status and, through the removal of nurse education from the health service, improved control by the occupational group of the body of knowledge and its development.

The adoption of the Project 2000 proposals by the Secretary of State for Health in May 1988, is positioned as a high point of professional influence on nurse education (publication 9). The substance of the proposals represented many of the aspirations of the profession and constituted a consensus at least across the professional nursing establishment. Dolan (1993), considered it 'hard to overstate the success of nursing compared to other professions at that
time. Faced with a radical conservative Government that was bent, it would appear, on breaking the power of the professions, nursing uniquely set its own agenda’ (P1).

Subsequently the implementation of Project 2000 involved a decision by ENB to increase the size of the “minimum learner population” of viable Schools of Nursing to 300 (ENB 1988). This change had the effect of provoking many School amalgamations and thereby severely attenuating the organisational intimacy between individual hospitals and their Schools of Nursing. At the same time the Schools were developing links with Higher Education Institutions in order to gain access to the Diploma of Higher Education awards. In due course all initial nurse training was institutionally relocated out of the National Health Service and into the Higher Education system. Table 1 provides a summary of some of the main policy documents over the period in question.

3.4 Enrolled nurses and care assistants

The origin of the modern occupation of nursing can be seen in the economic and social changes of the nineteenth century (Corrigan and Corrigan 1979). Nursing along with physiotherapy and social work, opened a form of professional life for women, while at the same time being constrained within predominantly patriarchal social structures (Hearn 1982). As a consequence, these occupations arose in areas which were thought of primarily as the concern of women. This legacy is still apparent in the relationship between nursing and medicine.

Commonly nursing’s relationship to medicine is positioned in terms of the relationship between “caring” and “curing”. While doctors may care about the well-being of the patient, their work is primarily devoted to the diagnosis and treatment of disease and illness (notwithstanding recently increased emphasis on health promotion and disease prevention). The nurse however is still regarded as being primarily devoted to the tending of the patient. Hence the notion that the nurse not only “cares about” but also “cares for” the patient. Caring has therefore been regarded as a fundamental and defining feature of nursing within the profession (Briggs 1972, Morrison and Burnard 1991).
TABLE 1 taken from Humphreys, J (1997)

Three policy trajectories relevant to the reform of English nurse education as revealed by the publication of significant
documents

<table>
<thead>
<tr>
<th>Year</th>
<th>Professionally led Reform: Nurse Education</th>
<th>Government led Reform: NHS Reorganisation</th>
<th>Government led Reform: Vocational Education &amp; Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>RCN Judge Report</td>
<td></td>
<td>WHITE PAPER – EDUCATION &amp; TRAINING FOR YOUNG PEOPLE</td>
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<tr>
<td></td>
<td>ENB Consultation Paper</td>
<td></td>
<td>WHITE PAPER – WORKING TOGETHER: EDUCATION &amp; TRAINING</td>
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<tr>
<td></td>
<td>Remove Schools from DHAs.</td>
<td></td>
<td>Competence &amp; Industry standards, NVQs &amp; NCVQ</td>
</tr>
<tr>
<td></td>
<td>Make students supernumerary</td>
<td></td>
<td>Training &amp; Enterprise Councils</td>
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<tr>
<td>1987</td>
<td>UKCC Project 2000: Final Proposals</td>
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<td></td>
<td>Nurse Education as HE</td>
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<td></td>
<td>Single level of nurse</td>
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<tr>
<td>1988</td>
<td>ENB Circular (ENB/13/APS)</td>
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<td>Minimum size for training organisation</td>
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<tr>
<td>1989</td>
<td>PEAT MARWICK MCLINTOCK</td>
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<tr>
<td></td>
<td>Review of statutory bodies</td>
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<tr>
<td></td>
<td>Proposed ENB to fund E&amp;T and manage schools</td>
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<td>1990</td>
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<td>1991</td>
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<tr>
<td>1992</td>
<td>EL(92)70 FUTURE MANAGEMENT OF COLLEGES OF HEALTH</td>
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<td>Narrows down options. HE becomes preferred option later in the year</td>
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<td>1994</td>
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<tr>
<td>1995</td>
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</tbody>
</table>
Furthermore, this “cares for” concept of caring is regarded by many (Davies, 1995, McFarlane, 1976) as an essentially holistic idea which, rather than being defined in terms of specific tasks can only be properly captured in the unbounded and broad sense of, as Davies (1995) has put it: “attending physically, mentally and emotionally to the needs of another and giving a commitment to the nurturance, growth and healing of that other.” (P141) Davies goes on to argue that in the public world of paid health care, the nurse is often structurally placed to achieve this, whereas the doctor is rarely so placed. On this basis, she argues that the practice of nursing legitimately “shades off” at one end of the spectrum into the medical and technical while at the other into domestic work. Such analyses have been applied in the papers submitted to reflect on the shift from two to one level of nurse and to examine in particular the case of the enrolled nurse. (Papers 9 and 15.)

In 1986, Project 2000 recommended the cessation of enrolled nurse training and the introduction of a new category of worker subsequently named the Health Care Assistant. The eventual achievement of the first of these left existing enrolled nurses as part of a diminishing staff group. Aware of the contentious nature of these proposals the UKCC recommended “that enhanced opportunities for enrolled nurses who opt for and are capable of progressing to current first level status should be given high priority”. However it rejected the proposal from the RCN that all enrolled nurses should be admitted to registered nurse status on the basis of a period of experience with no further formal training (UKCC 1986a). (See publication 15.)

In the event, Project 2000 created a large and vigorous market for “conversion” courses through which enrolled nurses could become registered. The widespread provision of such courses generally constituted a relatively successful response to the needs of this large and professionally marooned occupational sub-group. It was anticipated that 40,000 enrolled nurses would have successfully converted by the year 2000, with a wastage rate consistently below 5%, a figure which in the event compared very well with the annual drop out rate for initial registered nurse training programmes (7).

Despite the numbers of enrolled nurses converting, there was evidence that enrolled nurse conversion was not the consequence of a strong consensus within the professionally dominated statutory bodies with regard to facilitating the interests of enrolled nurses as a group. In fact, as publication 15 shows, for many senior nurses the best policy had appeared
to be to leave the great majority of enrolled nurses in their protected but increasingly limited position. Paper 15 quotes the ENB from their formal response to the Project 2000 proposals: "The Board do not agree that the options are “convert or nothing” ..... experience shows that only 10-15% of existing ENs are likely to have the capacity successfully to complete the necessary course". (ENB - 1986). Not only did this ENB estimate prove to be spectacularly incorrect (in fact 50% of ENs converted – see publication 7) but it also indicated (among other things) that the professional project of nursing embedded within Project 2000 was not collective. Rather than raising the status of all nurses, Project 2000 as we have seen effectively excluded around one third of the then nursing workforce from the professional project in order to raise the status of nursing. The fact that the second level nurses would be protected until retirement and/or given the opportunity to convert did not make Project 2000 collective in any real sense (Publication 15).

But the arguments for the demise of enrolled nurses were not at the time explicitly about professionalisation. Rather, the conclusion to terminate EN training was ostensibly a holistic category of argument of the sort elaborated by Davies. Quoting Pembrey (1985) the UKCC argued that the: "proper initial practitioner role does not exist; it is split between assisting (the role of the enrolled nurse) and managing (the role of the registered nurse in reality) and nursing drops through the vacuum in the middle" (UKCC 1986a).

However, later in the same chapter it was stated that: “In an ideal world, most would wish to see registered practitioners give all the care needed. It was always clear, however, that in the real world, the new practitioner could not practice alone. Just as s/he required advice, so there was a need for assistance”. Whatever may have led to the inclusion of the new helper in the Project 2000 proposals, these passages illustrate tensions within Project 2000.

On this basis I have argued that the primary motivation behind Project 2000 was not to solve the problem of nursing practice and the “vacuum” between the first and second level nurses. Rather, Project 2000 can only be properly explained if the primary motivation is assumed to have been more simply the professionalising goal of establishing nursing at a higher level, on this basis Project 2000 can be seen as a more coherent (if somewhat cryptic) document. Much of the conflict over Project 2000 from within the profession hinged on these points. While there was general agreement that the status of nurses should be raised, the Project 2000 approach appeared to contradict not only socialist ideas of collective action but also feminist
arguments that the way to professionalise nursing was not necessarily to move it towards the technical end, but rather to argue that the low esteem given to the broad idea of caring was part of a gendered conception of profession which should be tackled head on (see Witz 1992 for a general articulation of this category of position).

In my analysis I explain this conflict by showing that in England enrolled nurses were essentially being “sacrificed” to the priority of professionalisation which constituted the dominant motivation of the nursing establishment. In reaching this position I have been informed by a comparative study of the fate of enrolled nurses in Australia where nursing’s professional project did not involve the demise of the enrolled nurse level. In paper 14 this important distinction between England and Australia is explained in 3 ways: Firstly, there was a greater differentiation between the roles of the Australian Enrolled and Registered nurses than was the case in the UK at the time. EN training in Australia lasted for one year in the majority of Australian states compared to three years taken to train their Registered nurses. Secondly, the patterns of union membership in Australia were different from that in England. In particular Australia’s enrolled nurses by and large belonged to the Australian Nursing Federation: Enrolled nurse union membership was not so split between various unions as in England at the time and the Australian Nursing Federation did not suffer from the disadvantage of being somewhat marginal to a stronger staff-side power base, represented in England by the RCN (see below for an elaboration of the significance of this point). Thirdly, the main aim of the Australian professional project differed slightly but significantly from that in England. Whereas the key intention of the Australian profession had been to make registered nurse training a degree level activity – in England that aspiration never became a key component of the Project 2000 proposals. This left the need to distinguish between full blown professional nurses on the one hand and enrolled nurses on the other as a more critical component of the English project. Thus the study of Australian nurse professionalisation as well as being of interest in itself served to provide a comparative perspective which corroborated my detailed analysis of and explanation for English nurse development as a novel but nevertheless clear professional project.

Taking such matters together it is argued in my publications that policy development in English nurse education between 1985-1989 included as part of the professionalisation agenda, the reconceptualisation of nursing that is implicit in: The demise of the lower level Enrolled Nurse; the establishment of a new single level of practitioner corresponding roughly
to the old Registered Nurse but with HE training and higher level credentials; and the introduction of the health care assistant, who was (and is) not a nurse, below the new Registered Nurse.

Reflecting on the significance of this in terms of the labour market position of nursing prior to 1986, publication 15 maintains that the pre-1986 position, rather than being enhanced may even have been eroded. In the first place, the Health Care Assistant is not a nurse and therefore did not fall within the control of the professionally dominated statutory bodies for nursing. Secondly, the job of Health Care Assistant involved work which to a significant extent was previously the responsibility of trainee and/or enrolled nurses, who did fall within nursing’s statutory regulatory structure.

Linked to this potential weakening of the labour market position was the possibility in the longer term of a challenge to the nurses control over the work of caring. What emerged was a recognised occupational group clearly and explicitly distinct from nurses, whose responsibility it was to deliver care. Thus the “structural” position of nurses within the health service to attend “physically, mentally and emotionally” to the needs of others (Davies 1995 as quoted above) was no longer the reserved territory of nurses. On the basis of this analysis (somewhat more elaborated) I have made the case for bringing care assistants into nursing’s regulatory structure. (Francis and Humphreys, 1998)

Publication 15 in particular, examines how this occupational territory issue became apparent even as Project 2000 was being accepted in principle by the Government in May 1988. As a “principal point” the Secretary of State placed “great weight on the proposals: being marked up for a new range of support workers” (the aide or care assistant) and asserted the “need to develop a structure which can be placed within the National Vocational Qualifications training framework”. (DHSS 1988.) In fact as early as two months after the publication of the Project 2000 recommendations by UKCC in 1986, a white paper had been published entitled Working Together - Education and Training (Department of Employment, 1986) The white paper proposed the design and implementation of a new framework for vocational qualifications and led to the setting up of The National Council for Vocational Qualifications (NCVQ). In this environment it became inevitable (given the determination on the professional side that the helper would not be categorised as a nurse) that influence over the
health care assistant would, at least in the short term, to a significant extent slip further away from the nursing profession and towards employers.

Thus, contrasting priorities of the profession and the employers began to emerge with a degree of clarity. The professional agenda envisaged in due course a fully graduate nursing profession; specialist nurse practitioners encroaching on the work of doctors; nurse prescribing; and nursing led primary care general practices (employing doctors) while the employer agenda, suspicious of professional motives, continued to focus on the expense of nurses (and nurse education), the extent to which they were far from being flexible generic care workers, and reflected on the gap that enrolled and trainee nurses had formerly filled (NHSTA 1987, Jowett et al 1994, HSMU 1996, Manning 1997).

Publication 15 predicted that while common ground might emerge around a considerably enhanced role for nurses in the community setting, and perhaps in solving some of the issues around management and the workloads of junior doctors in acute settings, it was difficult to see how these sorts of enhanced roles could be achieved for nurses while at the same time maintaining the past and current levels of involvement in the direct delivery of care. In fact, in the two years from 1995 to 1997, the health care assistant contribution to the delivery of direct patient care increased at the expense of (enrolled) nurses. While in 1995 nurses (enrolled and registered) made up 95% of the direct patient care workforce – by 1997 that figure had dropped two percentage points - with a corresponding increase in care assistants.

There was also an accumulating supply of evidence suggesting that on the back of enhanced in-house training, health care assistants were indeed encroaching on some of the previously reserved territories of nursing and as Alderman (1997) reported, two thirds of Enrolled Nurses by then believed that they would be replaced by Health Care Assistants. That these issues reached to the heart of nursing was apparent from the debates going on within the profession which combined considerable enthusiasm over an enhanced professional role with anxiety over the possibly that in taking this path towards managing and “curing” they would gradually drift away from the broad caring role which was always both the centre of nurses practice, and the basis of their enormous public popularity.
3.5 Education and the professionalisation of nursing

In the context of my argument that Project 2000, although motivated primarily as a professional project, potentially had the counter-effect of eroding occupational control over caring, it has been instructive to examine how the UKCC came to their Project 2000 recommendations. On the basis of detailed work reported in Publication 15, I argue that UKCC’s commitment to the abolition of enrolled nursing developed in the apparent absence of any detailed articulation of either the case for such an action or indeed the pros and cons of alternatives (such as tackling unsatisfactory employment practices directly, or the transition model of Briggs (1972)).

These deficits in the articulation and appraisal of options in the Project 2000 development process meant that no real attempt was made during the formulation of the Project 2000 recommendations to determine the nature of the changes which might have most effectively achieved the stated goal of improving recruitment to nursing. I argue that in this analytical vacuum Project 2000 progressed inadequately grounded in terms both of the labour market situation and health service resourcing, with which it had at some point to engage.

This approach it is argued led the UKCC to finally agree their recommendations on 18 April 1986 (UKCC 1986a) before they had been costed – or the workforce implications explored. Evidence found in the UKCC archives indicated that analytical engagement between the professional priorities of the UKCC recommendations and the needs of the National Health Service occurred in October 1986 when Price Waterhouse (the management consultancy firm eventually commissioned by the UKCC to examine the costs and workforce implications of the recommendations) made a private presentation to the UKCC Council which demonstrated that the Project 2000 recommendations would “exacerbate manpower problems, lead to substantial increases in costs, and as a result would be unacceptable” (to Government) (UKCC 1986).

I have discovered and reported that there followed on 14 November - seven months after the UKCC finalised its recommendations - a confidential paper to Council members examining option packages in which some of the key proposals of Project 2000 were reconsidered (UKCC 1986b). In elucidating the Project 2000 process, this paper is highly significant. The paper included Price Waterhouse’s figures predicting that the Project 2000 proposals would lead to cumulative shortfalls by 2004 of 200,000 entrants to nursing and 70,000 qualified
nurses. Price Waterhouse also stated elsewhere that, of the options available, the continuation of EN training would have the biggest (by far) effect on redressing this shortfall (eg reducing the projected 1995 entrant deficit by 28%) (UKCC 1987). In the event UKCC rejected this advice and the only significant change to Project 2000 was to allow a 20% contribution to service by final year students, this being considered inadequate by Price Waterhouse who regarded the position adopted by the Council as a "high risk strategy" which could be seen as "placing most of the responsibility of the success or failure of Project 2000 on the service" (UKCC 1986b).

In reflecting on the detail of this late engagement with the workforce needs of the NHS, I conclude that education had provided the professionally dominated statutory bodies with what I refer to as the political space (ie free from the immediate priorities and direct involvement of the NHS) to assemble an ideal-driven wide-ranging professional project under the name of an educational reform. This political space was occupied by the UKCC and its Education Policy Advisory Committee in particular. The successful (possibly inadvertent) exploitation of this was a key to the "success" of Project 2000, for it enabled the nursing establishment to effectively promote a professional project whose character reached much further than the training of nurses. However, in this environment Project 2000 lost contact with the needs of the National Health Service and effectively established professionalising recommendations in an analytical vacuum.

As a consequence, at a critical formative stage in the development of recommendations, the UKCC failed to understand that although superficially attractive in professional terms, the demise of the enrolled nurse, combined with the introduction of the "aide" would as the TUC warned in a paper to UKCC:- "create a gap in patient care which the aide would inevitably be called on to fill" (TUC, n.d.). While this area had been occupied by enrolled and student nurses – it could now become filled by non-nurse aides (care assistants).

3.6 The nursing establishment and its limits

The case of the enrolled nurse and the limits of the professional consensus around Project 2000 has also been used in my work to elucidate the location and limits of power within nursing. Although the statutory bodies were committed to the changes, the response of representative bodies was variable. While the Royal College of Nursing supported the single
grade (RCN 1986) other staff organisations argued the continuing value of the second level nurse and were unconvinced by the arguments for her/his demise. The National Union of Public Employees (NUPE), for example, favoured the retention of the second level nurse (NUPE 1985), and the Confederation of Health Service Employees (COHSE n.d.), while supporting many of the Project 2000 proposals, argued that it left enrolled nurses ‘undervalued, rejected and betrayed by their own profession’. An explanation for this discrepancy in the positions of the staff side organisations is established in my work with reference to the traditions of these organisations and the consequent nature of their nursing membership (13).

I have moreover interpreted such considerations as consistent with the view that Project 2000 was essentially the product of a senior nursing establishment rather than of the profession as a whole and that, in fact, the strong consensus that undoubtedly existed in this establishment did not signify universal agreement within the ranks. Indeed, although the extent of disagreement may never now be known, it is reasonable to suggest that the majority of enrolled nurses would not have actively supported their own alienation from the mainstream nursing workforce. On this basis, it is plausible to suppose that around the time of Project 2000 up to 30% of the nursing workforce would have been against one of the central planks of the Project 2000 proposals. Moreover this figure excludes the substantial number of first level nurses who may also have felt threatened due to their lack of HE qualifications.

I have therefore argued that the content of the Project 2000 proposals were the product of a nursing establishment whose response to problems of nurse education and workforce supply was informed by a strong and sometimes explicit desire to improve the professional status of nursing. While this nursing establishment may have had good support among relatively senior NHS nurses (and through them the RCN), the probable absence of any true consensus outside the ranks of actual or aspiring senior nurses makes the severity of the proposals relating to enrolled nurses particularly interesting. It implies that the nursing establishment perceived itself (rightly) as powerful enough to publish and support proposals that would probably alienate a relatively high proportion of rank and file nurses.

The final and in the event unfulfilled component of the professional project related to the location and funding of the schools. While the UKCC and the national boards were heavily occupied with the Project 2000 development, the government had decided that the periodic
review that non-departmental statutory public bodies are subject to could be put off until after the Project 2000 work had been completed. In 1988, therefore, after ministers had given their agreement to the general thrust of Project 2000, the management consultants Peat Marwick McLintock (PMM) were commissioned to take another look at the roles and effectiveness of the UKCC, ENB and three other UK National Boards. The resulting report was critical of the then current arrangements for the funding of Schools of Nursing in which the National Boards paid for teaching staff involved in basic (pre-registration) training, while the District Health Authorities paid for post-registration training along with indirect costs relating for example to buildings and related services.

In early 1989 the consultants could identify only ‘two clear ways’ to improve the situation. The first was to give all the education and training funding to the District Health Authorities who would manage and be accountable for its use in the same way as any other NHS expenditure. The second was for the National Boards to take over the management of schools, becoming employers of their staff and responsible for their premises, etc. In the event, doubting the commitment of the Districts to education and training (having earlier praised the ‘dedication and professionalism of the members and officers of all the statutory bodies’) the final report recommended that the Boards ‘ be entrusted with the management and ownership of schools’ with the consequence that they should ‘sever their financial and managerial links with the NHS’ (Peat Marwick McLintock 1989).

Had the PMM recommendations been adopted, then the funding, regulation, management and provision of nurse education would all have been in the direct control of statutory bodies dominated by the profession. The English National Board for example would have routinely received funding from the Department of Health; it would have owned all the Schools of Nursing on which that funding was spent; it would have approved these schools and validated their courses as suitable vehicles for nurse education. Additionally it would have been the direct employer of all school staff. The professional control over nurse education would have been virtually total. Table 2 illustrates this point.
Actual and proposed arrangements for English Nurse Education between 1985 and 1996.

<table>
<thead>
<tr>
<th>Ownership of Schools</th>
<th>1985 (pre P2000)</th>
<th>b</th>
<th>1995 (post WP10)</th>
<th>1996+ EL(95)27</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHA (Employers)</td>
<td>ENB</td>
<td></td>
<td>Universities</td>
<td>Universities</td>
</tr>
<tr>
<td>Staffing of Schools</td>
<td>ENB</td>
<td></td>
<td>Universities</td>
<td>Universities</td>
</tr>
<tr>
<td>Funding of Schools</td>
<td>ENB</td>
<td></td>
<td>RHA</td>
<td>Consortia (including employers)</td>
</tr>
<tr>
<td>Approval of E&amp;T Provision</td>
<td>ENB</td>
<td></td>
<td>ENB</td>
<td>ENB</td>
</tr>
<tr>
<td>Status of Students</td>
<td>DHA (Employees)</td>
<td></td>
<td>Students</td>
<td>Students</td>
</tr>
</tbody>
</table>

Table 2  Taken from Humphreys, J (1997)
The PMM recommendations arguably reveal how such reviews cannot easily be independent of the context and prevailing ideology of their time. Perhaps most revealing in these terms is the question of whether a third serious alternative to the ‘two clear ways’ for nurse education funding actually existed at the time. Although the PMM report raised the possibility of Regional Health Authority (RHA) control of education funding, it was quickly dismissed as raising a ‘serious problem’ in that such an arrangement (while giving some guarantee that funding would be used appropriately) would separate the funding responsibility from the approval and ‘professional advice’ function which would (inevitably) be retained by the Boards. In fact even as the consultants conducted their review the publication in January 1989 of the White Paper, *Working for Patients*, heralded a new political agenda and the fundamental reorganisation of the NHS. In the new dispensation the separation of funding from professionally dominated approval processes would not at all be considered a ‘serious problem’.

3.7 The marketisation of nurse education 1989-1996

In 1988 the third Thatcher administration began a series of radical reforms in key parts of the welfare state. By and large these reforms involved a withdrawal of the state from the direct provision of services. Although state finance was largely retained, state provision would be replaced by systems of relatively independent providers competing to a greater or lesser extent in quasi or conventional markets. The second of these market developments was the National Health Service reform outlined in the White Paper, *Working for Patients* (Department of Health 1989) and implemented in the *National Health Service and Community Care Act* of 1990. This Act effectively split DHAs into distinct purchaser and provider units, while additionally introducing GP (general practitioner) fundholders who also acted as purchasers of secondary care services (such as hospital treatment). Subsequent to the 1990 Act, the DHAs in their purchasing role merged to form larger Health Authorities while the provision of secondary care services became the business of NHS Trusts.

While DHAs had contained within them both health service providers and nurse education providers, there was no particular reason to distinguish clearly between the costs of each service. At that time the funding of nurse education was derived from a variety of sources and was in fact very complex (Publication 1). Since the schools were by no means financially distinct organisations, their real costs were hidden within the overall financial
accounting systems of the DHA (Publication 4). In the context of NHS reform this position was problematic. For the new NHS internal market for health care to operate properly, there was a need to make an absolute distinction between the costs of health care delivery and the costs of health care education. If, for example, these monies remained conflated, and the new NHS Trusts as employers were asked to fund training, then they might be tempted to reduce the level (and cost) of training in order to achieve the short term advantage of reduced overall health service prices, at the expense of the long-term necessities of workforce supply and the ongoing professional development of their staff. Or conversely an NHS Trust committed to education and training could, through the extra costs entailed, put itself at a disadvantage in the short term by comparison with another. This possibly corrupting effect on the price mechanism of the internal market for health services was raised in the second working paper relating to Working for Patients, which suggested that "to avoid training ... being cut back it is necessary to remove these costs from (health service) pricing decisions".

As a response to the immediate need to separate out the funding of education and training from health service monies, the Government published a tenth working paper. Working Paper 10: Education and Training (Department of Health 1989) appeared only two months after the PMM report, but its recommendations were fundamentally different. While the PMM report emphasised centralised control of funding, autonomy of the training function, and the merits of professional involvement, Working Paper 10 proposed a devolved approach in which Regional Health Authorities working in consultation with employers (NHS Trusts) would have the main funding role for both pre and post registration education and training.

In February 1991, William Waldegrave (by then Secretary of State for Health) rejected Peat Marwick McLintock’s recommendations and announced the adoption as policy of Working Paper 10. As a central principle, he stated that decisions governing the supply of trained nurses ‘should be taken as close to the point of service delivery as possible, to ensure that such decisions are responsive to local needs and to the changing requirements of the employers’ (Department of Health 1991). In the same written parliamentary answer, while not resolving the issue of college management, he did explicitly rule out the possibility of ENB ownership.

In early 1992, the Department organised a series of consultative workshops involving education purchasers (by now regions) and education providers. Notes from one such
meeting, circulated by the ENB (1992), confirmed that continued ownership of schools by districts was considered untenable by the Department who at that time were also verbally ruling out the idea of independent status. In the context of such discussions, higher education was increasingly positioned as the ‘preferred natural home’ for nurse education and by October 1992 the NHS Management Executive was advising regions to facilitate ‘closer working arrangements’ between schools and higher education including ‘full integration were appropriate’ (EL(92)70). By 1992 therefore the elements in an incipient market for nurse education had become apparent. On the demand side regional health authorities advised by NHS Trusts would purchase both pre- and post-registration education and training services from a supply side consisting increasingly of major higher education institutions. The ENB would serve a sort of regulatory function through its residual role of validation and approval. In the event this arrangement remained in place until April 1996.

In May 1993, the final chapter (within the scope of this study) of education policy development commenced when the Department of Health set up a review to examine progress relating to the NHS reforms and identify areas for improvement. In the light of this review, the Secretary of State determined to streamline the management structure. Continuing the process of reform, it was decided to abolish the Regional Health Authorities and replace them with eight regional offices of a reorganised NHS Management Executive (subsequently renamed the NHS Executive) (Department of Health 1994). Since regions were by then education and training purchasers, in response to the anticipated abolition of RHAs, work commenced on yet another framework for planning and commissioning non-medical education and training, the results of which were published in March 1995 (EL(95)27). A principle element of this arrangement included consortia of NHS Trusts and others. Consortium functions included: collating workforce plans, estimating demand for newly qualified staff and increasingly “commissioning education direct from education providers”.

As a consequence of these developments, from April 1996 employers (NHS Trusts) were required to participate in consortia whose role was the commissioning of education from universities. As such, when contributing to purchasing decisions they had to consider the quality and cost effectiveness of the provision of particular universities. Bearing in mind the size of the contracts for which consortia were responsible, it is argued (4 and 9) that there were no precedents in the field of mainstream pre-service higher education in terms of the
direct and considerable powers that employers (collectively) then had over universities. The nature of this relationship and some of its implications has been ascertained through an analysis of the market structure.

While the above outline of policy development shows 1989 to be the starting point of the marketisation of nurse education, as I have shown first in Humphreys (1996) this should not be taken to imply that the eventual market dispensation was planned ab initio in the way that NHS reform was itself planned. In fact the period between 1989 (when Working Paper 10 was published) and 1992 (when higher education was positioned as the preferred natural home for nurse education) the market arrangement was emerging incrementally as the consequence of a complex policy process.

In fact, the final market configuration emerged not through any single decision (no document specifying the overall dispensation for nurse education was ever published between 1989 and 1995) but by an incremental process dominated and ultimately determined by two distinct and ideologically disparate policy processes. On the supply side, the introduction of the professionally dominated Project 2000 reforms continued to take their course (with the consequence of increasingly widespread and intimate relations between district schools and the mainstream higher education system) while on the demand side the more recently initiated but contiguous process of NHS reform combined a reduction of National Board (and therefore professional) influence with a total restructuring of the NHS.

My analysis of the creation of the market contrasts with more conventional answers to this question in the professional and academic nursing literature claiming that Working Paper 10 was designed to bring the New Right ideology to bear on nurse education. Burke (1995), for example, positioned Working Paper 10 as ‘an attempt to introduce the purchaser/provider split into NHS education and training’ and she went on to interpret Working Paper 10 in terms of the detailed principles of Conservative Party social policy at that time. Implicit in such analyses are rational models of policy decision-making in which policy development is analytical and goal-oriented. In fact, Working Paper 10 could best be interpreted not so much as an ideologically driven document moving towards Conservative Party ideals but rather as focused on immediate concerns and moving away from a problem rather than towards any particular educational goal, features which position it squarely as incremental in policy theory terms (Lindblom 1980). Furthermore the problem Working Paper 10 was designed to
overcome was not just an educational problem (such as wastage) but one relating to NHS
reform (namely the distortion of the price mechanism in the ‘internal market’ for health care,
publication 8) – hence my reference to ‘policy fallout’. So, whereas it may be possible to see
Working Paper 10 as part of a rational and goal-oriented process in relation to Health Policy,
it should not be interpreted primarily as a rational attempt to inject New Right principles into
nurse education. This point echoes Rafferty’s (1996) conclusion, based on a study of nurse
education between 1860 and 1948, on the importance of general welfare policy in nurse
education development.

On the basis of my conclusions, one might predict that had the professional project been left
to run its course in the political environment in which it commenced, then nurse education
funding would have ended up outside the NHS within a statutory body for nursing or most
likely in due course with the main UK HE funder (HEFCE). Such a prediction is of more
than just hypothetical interest as I have tested it by international comparison (publication 12).
While the Thatcher government as I have shown did not set out to create a market for nurse
education, it did in its NHS reform reflect what Scott (1996) called the “deep structure” of
Thatcherite opinion: namely respect for employers and suspicion of professional interests:
values which when combined with the insular mentality of an occupation reflecting on the
apparent success of Project 2000 made the removal of education funding from the NHS
highly unlikely. In contrast the Australian professional project came to fruition under a
labour government and the logic of shifting funds from the health to the education branches
of government had taken its course before the Australian equivalent of Thatcher policy
agenda had gained momentum. So while the intersection of two very different policy
trajectories resulted in a peculiar arrangement in England, the lack of such an interception
resulted in a conventional position in Australia in which both nurse education and its funding
fall under the education branch of Government (12). Thus the Australian comparative work
corroborates my English ‘two intersecting trajectories’ analysis.

4 THE NATURE AND IMPLICATIONS OF THE MARKET

4.1 The market structure

The implementation of Working Paper 10 brought all education providers to a greater or
lesser degree within the scope of market forces. For many providers the reality of this new
market became a tangible feature of their environment at the point at which they left the District Health Authority and found themselves outside the NHS. With an accumulating professional literature analysing the significance of the changes for providers, it became widely recognised as ‘probable that the institution which continues in a basically reactive mode is unlikely to weather the storm of change’ (Fields 1991). Publication 1 represents an early analysis positioning the new arrangements as (at that time) a putative market. That paper identified a ‘marketing gap’ between the new marketing oriented approaches likely to be necessary and the established practices of many colleges. Subsequent publications (including Ramsammy and Humphreys (1994)) examine processes of incorporation of colleges of health care studies to higher education institutions along with suggestions as to appropriate management structures. These propositions were informed by a recognition of the significance of the shift from colleges as part of district health authorities to colleges as part of a corporate organisation (normally a polytechnic) outside the NHS. Subsequent work was conducted to precisely define the character of the market as is outlined below.

In an orthodox market for services a supply side addresses the needs of a demand side composed of consumers making purchasing decisions. In the absence of a monopoly, consumer choice signifies competition between providers who seek to secure or expand their market share. In conventional markets, the purchaser is also normally the direct user or recipient of the service. However in the NHS internal market configuration of the time the purchaser was (and still is) not the direct recipient of services. Instead districts (along with GP fundholders) were given the role of purchasing health services on behalf of their local communities who at the point of access became consumers. Since the decisions of purchaser-recipient consumers are central to conventional market theory, markets in which purchasing and consumption are distinct cannot be analysed in orthodox terms. Such arrangements have been described by Le Grand and Bartlett (1993) as ‘quasi-markets’.

My application of quasi-market theory to the arrangements for nurse education is an original contribution sustained over a number of papers which include an elaboration of the market components and, on the basis of deduction and empirical work, identification of the character and implications of the market. In addition to examining the distinctions between conventional and quasi-markets, Publication 8 also indicates an important difference between two relatively standard quasi-markets (for health services and most higher education) on the one hand, and non-medical education and training (including nurse education) on the other.
Essentially, the non-medical education and training quasi-market of the time is shown to have had a more complex demand side with two recipients. Firstly the NHS Trust employer for whom pre-registration education and training fulfilled workforce supply services and secondly the student consumer seeking the qualifications and skills necessary for clinical practice.

The positioning of the employer as a direct (rather than only indirect) recipient of pre-service education and training services is argued as a special characteristic of the non-medical education and training market which is not apparent in the general higher education market. This difference was a consequence of the devolved (rather than national) nature of the non-medical education and training market combined with the fact that non-medical education and training is a ‘monotechnic’ market in which only those subjects of relevance to one type of employer (health care provider organisations) are purchased. In the context of an historically close relationship between health care educators and health care providers (and the consequently highly integrated nature of theory and clinical practice in many nursing courses) these two features of the non-medical education and training market have ensured that individual nurse education provider organisations remains in very close relationship with their local employer ‘clients’ (the NHS Trusts). This remains the case at least in comparison to the generality of Higher Education. Furthermore the direct nature of this link in market terms was signified by encouragement in Working Paper 10 for regions to involve employers in purchasing decisions, and was eventually formalised by the establishment of commissioning consortia as mandatory (8).

Overall therefore the arrangements for non-medical education and training constituted a quasi-market in which the presence of employers added a novel complexity to the demand side. This conclusion on the uniqueness of the market structure provokes two questions: firstly regarding the effects of demand side complexity per se and secondly concerning the unusual powers of employers in the market (and the implications of these powers for the supply side).

4.2 Corporate instrumentalism and demand side tensions

As I have outlined, a point of particular interest in the quasi-market structure is the fact that the complex demand side included two types of organisation (regions, or later consortia, and
NHS Trusts) rather than only one organisation and one group of individuals (such as students or patients) as is the case in other quasi-markets. This analysis raised the particular issue as to whether the organisational priorities and even ideologies of the demand side organisations were aligned in the purchasing process. This question was first raised in a publication which compares and contrasts professional and corporate priorities both in broad terms and in the context of the particular purposes of education and training. That work, (4 and 5) on the basis of literature review, hypothesised tensions on the demand side of the market, which was followed up by empirical work reported in publication 6. In particular, the empirical work revealed some scepticism amongst NHS Trust chief executives in one Regional Health Authority area. While many chief executives accepted the potential significance of education and training for both quality of service and the strategic development of their corporate organisations (part of an ideological position named as ‘corporate instrumentalism’ in 4 and 6) and also believed in the capability of markets in general to ensure responsiveness in providers, they nevertheless doubted whether the particular arrangements under Working Paper 10 would be effective in ensuring that nurse education providers would produce the sort of new practitioners needed for a reformed NHS.

To emphasise this point, Publication 8 rehearses the fundamental nature of NHS reform at that time: with NHS Trusts by then operating in their own competitive quasi-markets, the question of costs had become central (rather than incidental) to service delivery. One effect of this was to create the need for new approaches to the delivery of care with consequent shifts in the nursing role. The need for and nature of these new approaches to nursing were manifest in extensive debates within nursing about skill-mix, role boundaries, nurses as managers, and also ideology and value issues. In this context, NHS Trust chief executives were found to be sceptical about the appropriateness of regions as education and training purchasers, feeling that they would be ‘out of touch’, ‘remote from the action’ and consequently unable to purchase on the basis of a full knowledge of the ‘real world priorities’ of NHS Trusts. Furthermore for some chief executives the Working Paper 10 quasi-market constituted a mechanism through which Regional Health Authorities would inevitably (although not necessarily intentionally) prioritise the professional ‘territorial rights’ of nurses above the needs of a reformed NHS and its Trusts (6). For a significant proportion of these chief executives the arrangements for nurse education were flawed to such an extent that they favoured the replacement of Working Paper 10 with a conventional
(rather than quasi-) market in which all monies for education and training were disbursed amongst individual trusts for direct purchasing from education providers.

Thus the complex non-medical education and training quasi-market under Working Paper 10 did indeed have severe tensions on the demand side – created not as a general consequence of there being three demand side participants but rather due to the particular fact that two of these demand side participants were organisations who appeared to differ in their priorities.

Publication 9 shows how the devolution to Regions of Working Paper 10 implementation led to great variations between the character of the English regional markets which ranged from fully reformed demand-dominated systems to ‘soft’ markets in which historical patterns of delivery were largely maintained until relatively late in the reform process. In fact in their most strident manifestation Working Paper 10 consortia drew a line under historical patterns of provision and put all contracts out to national tender.

4.3 The co-ordination of supply and demand

From the elucidation and analysis of nurse education policy between 1985 and 1996 outlined above, it has been possible to derive two general points. Firstly that the policy process in relation to nurse education was in various ways peculiar and secondly that the dispensation resulting from that process was unique. In summary, essentially a quasi-market, in which a complex demand side gave employers considerable collective power as purchasers, had arisen from a severely incremental policy process involving the intersection of two relatively distinct policy trajectories neither of which had the nature of the resulting overall educational dispensation as its primary concern. In the event the professional project was the primary influence on supply side development while NHS reform dominated the development of the demand side. The resulting arrangements I have described as hybrid – lying somewhere between conventional models of professional education provided by universities and funded ultimately by the education branch of government (such as architecture) and high-level in-house training funded and provided by corporate business organisations (such as for commercial pilots).

This analysis raised the question as to whether the nurse education market was by its nature in a position to respond effectively to the new needs of employers going through the process
of radical NHS reform. Considering the significance of NHS reform discussed in terms of changes in nurse skill-mix, role boundaries, nurses as managers, value issues etc, the challenge for the non-medical education and training quasi-markets clearly went well beyond the simple production of a numerically sufficient workforce supply. Crucially therefore the education and training quasi-market should be capable of co-ordinating not only quantitative but also qualitative features of the nurse output with new patterns of demand. This, despite the fact that health care services and nurse education were co-ordinated though clearly separate quasi-markets with separate funding – distinct demand-side components and supply-side organisations separated not just by their traditions and corporate individuality but also by the fact that they fell under different government departments.

It is argued that whatever the pros and cons of NHS reform, if these two markets were not harmonised (ie the smaller nurse education and training market meeting staffing needs generated in the larger health service market and therefore being effective in co-ordinating supply and demand) then the two-market dispensation would be flawed in policy terms, and this in turn could impede rather than facilitate NHS reform (Stanwick & Humphreys 1996). Furthermore this question mark raised over the capacity of the two-market arrangement to generate harmonisation (and therefore a good match between qualitative aspects of workforce demand and supply) was not simply hypothetical. Evidence of tensions within the complex demand-side of the non-medical education and training quasi-market had already been established and indeed it was known that some NHS Trust chief executives believed that a “political orientation” within non-medical education and training could “protect traditional values or at least hinder the changes they are expected to achieve” (6).

In considering the nature of the nurse education market, it is necessary therefore, in addition to analysing its structure and the features of its demand and supply sides, to consider its actual performance as an effective means of coordinating services. ie to produce a sufficiency of nurses in terms of both quantity and quality. On the quantitative side, publication 9 shows the total number of entries on to pre-registration nurse training courses in each of the ten years from 1985 to 1995. In addition to revealing the effects of professionally led policies such as the replacement of conventional courses with Project 2000, and the cessation of level 2 training, the figures also reveal a significant downturn in first level entry from a high point of 16,864 in 1991-92 to 10,844 in 1994-95. Publication 10 examines in detail the capacity of the quasi-markets to deliver quantitative co-ordination between supply and demand ie to
ensure an appropriate supply of nurses. The paper concludes that the utility of consortia in relation to workforce planning was limited and showed how central intervention informed the commissioning processes.

Subsequently, publication 12 examined the effectiveness of local commissioning arrangements through a comparison of commissioning policy across the four UK nations. That paper notes that, while devolution to local employers had been attempted in England, in the other UK nations commissioning had, if anything, become more centralised. Moreover, while practical issues may have played a part in the non-adoption of the consortium approach in the other UK nations, concerns over accurate co-ordination of numerical demand for nurses emanating from the respective government offices constituted a principal reason for their reversion to a centralised system. Noting again how the NHS Executive in England was still modelling workforce supply figures centrally and moreover, taking a guiding role in the commissioning process (argued as necessary due to past planning errors and lack of information at consortium level regarding the number of student nurse recruits necessary) paper 12 suggested that, if the NHS Executive was forced to continue its involvement in quantitative aspects of education commissioning, then the argument would become compelling that central planning was actually more effective and indeed, cost effective approach to co-ordinating supply and demand. Future work will examine subsequent development in this context.

However, it is also recognised that local commissioning could have had advantages at the time that could not be delivered through a central planning process: namely relating to the qualitative co-ordination of supply and demand. That is to say the delivery of trained nurses, whose skills match closely the specific demands of work places represented by the particular NHS Trusts, having membership of a local consortium. This aspect is examined most particularly in publication 8 which addresses both practical and theoretical issues pertinent to the capacity of the market to deliver qualitative co-ordination. That paper, on the basis of direct observation of purchaser activity and in the context of the quasi-market analysis, identified the nature of demand side behaviour which would most likely lead to effective qualitative co-ordination. It also examines cost effectiveness and a possible mechanism through which a quasi-market might suppress educational innovation. All of these constituted original analyses and contributed to the development of consortium practice across England (see section 6).
4.4 Supply side practice

Whilst the above mentioned papers examine those behaviours on the demand side which would be most likely to facilitate effective functioning of the market, a number of other papers examine the implications of the market for providers of education, including behaviours on the supply side which would be likely to enhance co-ordination and secure contracts.

The corporate college analysis in publication 3 constituted an insight which led to the argument for a paradigm shift within health care education, this being the theme of the edited book Humphreys and Quinn (1994) and in particular, various chapters within it including publication 2. Publications 2 and 4 identify features of two paradigms of health-care education which were regarded as conflicting - and subsequent work based on the identification of the incipient new paradigm includes development of a new model of curriculum development based on the combination of 'new product development' method from the discipline of marketing and curriculum theory from education (publication 4).

The position of the nurse tutor within the corporate organisation and market is discussed in publication 5 which further refines the paradigm shift proposition. It argues that at the centre of these changes were the individual nurse teachers struggling to identify a new role. By 1996, the vast majority were employed outside the NHS (in universities) and answerable through the market to the unfamiliar ideologies of corporate NHS Trusts managers. These Trusts, as we have seen, had considerable degrees of power within the market and were pressing for change in nurse education (and the resulting nurses) in ways more compatible with their own corporate imperatives than the prevailing professional priorities implicit in the conventional nurse tutor role. Thus in accommodating their new positions and reconciling the diverse tensions upon them, nurse teachers were encouraged to adopt new approaches and, more fundamentally, new paradigms within which to practice.

5 CONCLUSION

The introduction to this exposition identified that the papers submitted represent an attempt to analyse, explain and sometimes influence aspects of policy and practice in relation to nurse
education. The question of influence and impact is considered in the next section. In this conclusion I will seek to briefly summarise some of the main findings of the work in the context of the original three primary research questions concerning: the policy processes involved, and the nature of the arrangements that emerged and the implications of these arrangements.

The work establishes explanatory links between these arrangements for nurse education and the policy process that generated them. Broadly this analysis positions the development of nurse education within the scope of incremental policy theory of the sort associated with Charles Lindblom. In general terms the work shows that the arrangements for nurse education in place by 1997 were the result of an interaction between clearly distinct but chronological overlapping policy processes the first relating to the professionalisation of nursing and second relating to the reform of the National Health Service. Through analysis of UK policy development along with a comparative analysis of that process in relation to its Australian counterpart it has been shown how the intersecting trajectories of nurse professionalisation and NHS reform led to an eventual position which had not been anticipated in either. This conclusion emerged from a detailed assessment of the development of the policy in relation to both Project 2000 and Working Paper 10, a process which also revealed clear distinctions between the rhetoric of the policy agendas and the pragmatism of the actions.

The arrangements for nurse education in place by 1997 have been shown to be a quasi market with peculiar complexity due primary to the nature of the demand side. Empirical and other work revealed ideological inconsistencies between players within the market which it has been argued were sufficiently incompatible as to be paradigmatic. It has been shown also that such tensions were apparent not only between supply and demand sides but also within the demand side, partly as a consequence of the unusual complexity of this component of the market. This complexity along with the relationship between the demand side of the education market and the supply side of the larger NHS ‘internal market’ have been the basis for my assertion of the novelty of the market in the context of general quasi market theory.

The market has also been shown to be novel in terms of the amount of control that it gives to employers over higher education provision and the extent to which funding into higher education is derived from sources outside the scope of the education branch of government
and the implications of the market for education provides – at both individual lecturer and at institutional level have been analysed in terms of these key features.

As a case study of professionalisation two particular contributions are noteworthy. The first relating to the handling of the enrolled nurse situation in the UK (again elucidated by Australian comparison) and the second relating to education as providing the ‘political space’ in which the professional project could be established with momentum, relatively protected from workforce issues. In tracking the consequences that followed the eventual re-engagement between workforce supply and the professional project I have been able to make contributions in terms of the relationship between nursing and caring, and matters relating to the regulation of the activities of care assistants. Additionally, the work on enrolled nurses - in particular their capacity when given the opportunity to successfully convert to registered nurse status - has also led to publications examining both the motivation of groups to engage with higher education and the incompatibility between professional education boundary effects and the government’s concept of lifelong learning.

As a study of the development of nurse education policy the work presented corroborates some conclusions reached by Rafferty (1996) in a study of the period between 1860 and 1948. In particular her recognition of: the importance of nurse recruitment as a factor in education policy; the importance of welfare policy in explaining nurse education reform, and the significance of moments of convergence between government and occupational priorities.

Finally my work has defined effective practice on both supply and demand sides of the education market in relation to both quantitative (relating to the numerical supply of nurses) and qualitative issues. The latter relating most particularly to the match between nursing skills and the demands of the work place, along with issues relating to quality and innovation. This has included development of a new model of curriculum development derived from a synthesis of marketing and educational theory.
IMPACTS

The impact of my work has focused primarily on two communities, the first academic and the second professional. These will be considered in turn.

With regard to the academic community it is probably fair to say that I have put nurse education on the ‘map’ for education policy theorists some of whom would not otherwise have recognised the importance of professional education policy as a subset of the broader field of education policy generally. Conference papers, for example, have been well received and my papers in the mainstream high status *Journal of Education Policy* have created significant interest in this previously largely neglected but important area of education policy development. My ability to set health care education policy in the broader context of educational policy studies has also led me to provide insights for health care education specialists which have enabled them to better understand how nurse education reached a unique position in education policy terms with regard to the extent to which employers had power over providers, and other peculiarities relating to the flow of health ministry funding to an education ministry industry. This connection between general education policy and health care education policy is a particular feature of my work which has been generally welcomed and, in consequence, I have managed to achieve citations which cross a normally fairly watertight boundary while also being asked by ESRC to evaluate research funded by them.

A further area of academic impact derived from my decision to follow Gerwitz et al (1995) in the general education market by designing a programme of research which, rather than focusing on one component of the market, instead examined each component of the market in such a way that an overall understanding of its origins and implications could be achieved. On this basis alone I have been able to develop a complete explanation of the origins of the market through analysis which combines scrutiny of both nurse professionalisation and NHS reform. This original approach has led to my paper of 1996 entitled ‘English Nurse Education and the Reform of the National Health Service’ becoming arguably, on the basis of repeated citations between 1996 and 2002, the definitive account and explanation of developments in nurse education policy over the important period 1985 - 1997. Furthermore this
paper, although published in a general education journal, has been one of those that
has transcended the boundary into the specialist health care education community of
academics, as well as being used by education policy academics more generally.

My work has also had impact on policy makers and practitioners within the education
market on both the supply and demand sides. Essentially I would argue that, more
than any other researcher, I defined effective practice for both contractors on the
demand side and providers on the supply side.

The impacts of the supply-side work took two forms. Firstly, through influences on
the approaches taken in supply side organisations, and secondly, through particular
educational initiatives whose development was based on the new approaches outlined
in the exposition. These will be considered in turn.

Publications 1 and the book (Humphreys and Quinn, 1994) generated considerable
demand for work by the author to assist colleges come to terms with and adopt
operational models compatible with the emerging market arrangements. Further, the
book in particular, is known anecdotally to have been used by various colleges as a
source of models for development.

Walker and Humphreys (1994) Humphreys and Ham (1994) and Quinn, Phillips,
Humphreys and Hull (1997) provide details of two innovative educational
developments. One accelerating the national shift of physiotherapy CPD into HEIs
(acting as a catalyst in this respect). The other, enabling those nurses wishing to
upgrade their qualifications as a consequence of the advent of Project 2000
programmes to do so. (A scheme in collaboration with Macmillan Magazines which
captured a disproportionally high percentage of the national market.)

Ramsammy and Humphreys (1994) and Dickinson et al (1994) (including
Humphreys) describe and evaluate approaches developed for the successful
incorporation of Colleges of Health Care Studies into HEIs. This development was a
relatively early incorporation which preceded the stipulation that “transfer of
undertakings” legislation would be appropriate and available for such incorporations.
In the event, all staff transferred on a voluntary basis. The supply side work also led
to various conference invitations including a keynote speech to a HEIST conference on Marketing for Nursing and Healthcare Education on 28 October 1997 in Birmingham.

On the demand side, Humphreys and Davies (1995) and parts of 8 report actual consortium development work conducted for a Regional Health Authority – the first relating to education quality assurance processes and the second to consortium structure and function. The resulting arrangements were commended in an internal (unpublished) Department of Health report on consortium implementation.

As a result of 6, I was asked to write a ‘commentary’ article for Nursing Standard in which I called for moderation on both sides of the market. (Humphreys 1996). Paper 12 provoked an editorial commentary by the journal concerned summarising the paper and adding editorial comment (which I have attached to the paper).

To finish I would like to argue that, among those British researchers publishing in the area of health care education policy, I have been pre-eminent in both policy development and policy implementation terms. There are two particular moments which illustrate this position. The first in 1996 when I published two papers which demonstrated a complete command over the subject matter, well beyond any other researcher at that time. The first: Education Commissioning by Consortia: some theoretical and practical issues ..... This paper which was pushed to fast publication by the journal concerned was recognised as analytically markedly ahead of anything else in the field at the time. The second paper in 1996 was English Nurse Education and the reform of the NHS which, as I have mentioned above, provided what has emerged as the definitive explanation of the origin of the market.

In the year 2000 I had the first two papers in the third issue of the Journal of Education Policy. The first entitled ‘Education and the Professionalisation of Nursing’ and the second ‘Professional Education as Structural Barrier to Lifelong Learning’. The Journal of Education Policy is probably the top journal world-wide in its field and for one author to have the first two papers in any issue is I think unprecedented. The second of these papers was subsequently published in a collection on lifelong learning by Routledge Farmer. A summary of the argument of
the paper was also published in Nursing Standard in 1999 (Francis and Humphreys 1999) and cited in the UKCC Peach Report later that year.

To add a level of objectivity to my various assertions above, below I list some citations of my work in relation to the emergence of the market, the nature and implications of the market and then more particularly the implications for educators and employers.

CITATIONS

The Emergence of the Market

Davies (2002) Cites 9
* Cites the “accidental market” theory and the assertion that the market had no precedents in mainstream higher education.

* Uses interpretation and analyses from these papers in an account of developments in funding arrangements and consortia.

Dowswell, Hewison and Millar (1998a) Cites 9
* Evidences the opposition to Project 2000 and uses the ‘nursing establishment’ interpretation in 13.

Dowswell, Hewison and Millar (1998b) Cites 9
* Again acknowledges the argument in 9 that a nursing establishment acted against the interests of the ‘rank and file’.

* Uses these as sources for assertions regarding the development of a market with significant employer control.
Meerabeau (1998) Cites 9
* Cites a number of interpretations from 9 a part of as general critical review reflecting on the identity of nursing.

Meerabeau (2000) Cites 9
* Uses a number of the assertions and analyses of 9 including: the ‘accidental market’ theory; the significance of the overlapping membership of UKCC and the National Boards in resisting the campaign of COHSE against the demise of the enrolled nurse etc.

Meerabeau (2001) Cites 9
* Uses the intersecting policy trajectory explanation in 9 along with its reflections on the professional project with regard to the enrolled nurse. Also cites the point that overlapping National Board and UKCC membership enhanced the capacity of the nursing establishment to promote the Project 2000 agenda.

The Nature and Implications of the Market

Burke (1995) Cites 1
* Cites the point that Regional purchasers did not constitute a real market, and the position of NHS Trusts as ‘consumers’ (this being a putative form of the later quasi-market analysis).

Cowley (1999) Cites 8
* Uses the contract made between mainstream higher education and nurse education with regard to employer control over funding.

Webb (1999) Cites 7
* Uses data on EN conversion collated and reported in 7.

* This report of the UKCC Commission for Nursing and Midwifery Education includes this paper in its bibliography. The paper includes a summary of the more detailed arguments of 16.
Meerabeau (2000) Cites 10, 13, 9
* Uses these to evidence some significant differences of market character between England on the one hand, and the other UK nations and Australia on the other.

Swindells, C (1996) Cites 6, and Humphreys and Davies
* Uses the quasi market analysis to characterise the arrangements for nurse education.

* Cites 9 in terms of the significance of employers in consortia.

**Implications for Educators and Employers**

Crapnell (1995) Cites 1
* Quotes the point that historical relationships and boundaries would not provide the rationale for contracts under the new arrangements and that colleges would need to develop new approaches. This in the context of the development of postgraduate surgical courses.

Hewison and Wildman (1996) Cites 2
* Uses the paradigm incompatibility argument between corporate and professional priorities, and the assertion that NHS reform has revolutionary implications for nurse education as a base for exploring the implications of these ideas further with special reference to the theory – practice gap. Asserting a ‘paradox’ that the emergent educational paradigm identified in 3 may reduce the theory practice gap while at the same time threatening the future of professional nursing.

Rushforth and Ireland (1997) Cites 3 and 6
* Uses the assertion from 3 that local rather than national arrangements are atypical and examines this in relation to the effectiveness of ‘manpower planning’ (sic). Also identifies some merits of corporate instrumentalism (6) for post-
registration provision but asserts that it is fundamentally flawed as an ideological base for pre-registration provision.

Callery (2000) Cites 12
* Uses the assertion of the link between NHS reform and the marketisation of nurse education and of the difficulties of NHS Trusts in advising effectively on the demand side.

Corres (1998) Cites 6
* Uses evidence from 6 on NHS Trust scepticism with regard to the commitment of education providers to the needs and values of the new NHS. Also uses the ‘two market’ analysis and the need for strategic alignment between them.

Corbett (1998) Cites 6 and 8
* Cites these two papers extensively as an evidence and interpretational base for arguing that nurse educators are becoming deskillled due to the relocation of clinical nursing knowledge out of education providers and more exclusively into NHS Trusts.

Macleod Clark (1998) Cites 6
* Included in a references and bibliography section of a published lecture.

Nolan et al (2000) Cites 2.4.10
* Cites the paradigmatic incompatibility argument between professional and corporate models of education and training as a basis for examining conceptions of continuing professional development on the demand side.

Roberts (1998) Cites 1
* Uses the marketing gap analysis in various ways to build an argument for relationship marketing.

Roberts and Barriball (1999) Cites 1,6,8
* In a section on the management of nurse education, uses these papers to evidence the development of consortia and disseminates the complex quasi-market analysis of 6 and 8.
* Cited in relation to the assertion that planning deficits in consortia led to a recruitment crisis in nursing. Francis and Humphreys (1998) summarises the more detailed work reported in 12.

* Identifies the developments reported in 6 as a ‘notable exception’ to the slow development of consortia. Cites Humphreys and Quinn (1994) as a source of detailed explanation of the changes in nurse education. Uses the point in 4 that education funds were ‘hidden’ within the Health Authorities’ overall accounting systems as an explanation for his assertion that workforce planning received little serious attention in the early days of the internal market.

* Reference to the vulnerability of providers in relation to training contracts.

* Identifies the work reported as one of the innovations that made possible the increased access to enrolled nurse conversion courses at a time of high demand and questions the original estimate of the EN conversion market (Hemsley-Brown and Humphreys (1997) is a summary report of 7).

* In which evidence from 10 is used as a rationale for an evaluation of the effects of post registration education on subsequent clinical practice (which they report)

* Uses evidence in 8 of central interventions to rectify local workforce planning deficits in England. Cites Francis and Humphreys as evidence for cross market collaboration as a basis for arguing that consortia may constitute models of good practice which could be generalised to good effect. (While acknowledging the
assertion in 8 that innovation could be stifled through process-focused quality assurance.)

* Swindells, C (1996) Cites 1
Cites the ‘marketing gap’ analysis in 1 as a basis for examining the advantages of a market orientation in Schools of Nursing.
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B ASSESSMENT OF MULTI-AUTHOR CONTRIBUTIONS

All the collaborative publications are reporting work led by myself, and in which the conceptual underpinning and direction of the work was based on my own analysis, initiative and (when applicable) acquisition of funds. I can legitimately claim to be identified as the creator and prime mover of the research programme, the originator of the key analytical insights, the significant steps forward and the major original contributions. Should the case for this need arguing further, I would draw attention to a number of key single author contributions (1,4,5,6,8,9,15 plus Humphreys, 1997) which represent a sort of analytical strategic spine to the work as a whole as well as establishing my personal priority with regard to the significant contributions that are claimed in the exposition. It is in this (somewhat immodest) context that I must recognise below the undoubtedly valuable associations I have had with a number of very able collaborators.

Publication 2 Humphreys and Quinn
Frank Quinn was Head of Health Care Education in the School of PCET. The book was an examination and expansion of some of the issues raised in Humphreys (1993) (1), and was developed and executed by Frank Quinn and myself as equal partners. I wrote 2 myself although as the introduction to the book we published it together.

Publication 3 Bailey and Humphreys
The analysis of the position of the corporate college was largely mine—developed for a number of consultancy projects. My colleague, Bill Bailey, was interested in writing it up using the ‘backbone’ of analytical diagrams which I had done already.

Publications 7&11 Hemsley-Brown and Humphreys
Jane Hemsley-Brown was a research fellow employed by me to look particularly at the enrolled nurse position. She conducted all her work under my direct supervision but in paper 11, the method and categories of motivation for higher education participation originated with her.
Francis and Humphreys

Becky Francis was also a research fellow (replacing Jane Hemsley-Brown) and worked under my direct supervision. Our pattern of working was the same as for Jane. I would outline a thesis and she would work it up into a paper. For example, the two papers comparing UK and Australia were initiated by myself on the basis of initial literature work followed by a study visit to Curtin University in Perth. The conclusions I reached were worked up by Becky under my supervision. However, her contribution was greater than just writing up. Essentially under my guidance she tested the robustness of my analysis and thereby exerted influence on what emerged.
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<td>2</td>
<td>Humphreys J and Quinn F M (1994)</td>
<td>Health Care Education: Towards a corporate paradigm</td>
<td>In Humphreys and Quinn op cit. 1-9</td>
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<td>Bailey B and Humphreys J (1994)</td>
<td>The position of the Corporate College</td>
<td>In Humphreys and Quinn op cit. 91-101</td>
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<td>4</td>
<td>Humphreys J (1994)</td>
<td>New Models in a Corporate Paradigm.</td>
<td>In Humphreys and Quinn op cit. 141-169</td>
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<td>5</td>
<td>Humphreys J (1995)</td>
<td>Paradigms of Practice: A Dilemma for Nurse Educators.</td>
<td>The Vocational Aspect of Education 47(2) 113-127</td>
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12 Francis, B and Humphreys, J (1998) Devolution or centralisation? Differences in the development of nurse education commissioning policies among the UK nations. 
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PART D

THE SUBMITTED PUBLICATIONS
The marketing gap in health care education

John Humphreys

Through an analysis of some of the implications of Health Service re-organisation for colleges (and faculties), this paper argues the need for marketing practices in colleges and identifies a 'marketing gap' between the approaches commonly employed and those needed to secure a significant future role.

INTRODUCTION

This paper represents an analysis of some of the implications of the present reorganisation of the National Health Service (NHS) for colleges of health care studies. Although it is established that the changed role of districts, and the new relationships between colleges and service providers represents a significant change for colleges (e.g. Booth 1992) the full implications for nurse education have not yet permeated the large proportion of college staff, nor indeed has the subject yet received full scrutiny in the professional journals. It is hoped that by considering the need for client-led approaches in nurse education, that some issues of significance for the future of colleges will be clarified.

Historically most colleges of nursing and midwifery have had no legal standing other than as departments of a sort within District Health Authorities (DHA). In this situation, the provider of health care has also been the provider of education and training for health care professionals, which has therefore been essentially an 'in-house' provision. The removal of districts from direct involvement in health care provision is coinciding with a shift of colleges into detached and more independent status; very often due to established links through P2000 and political will, into a local higher education institution. Whatever the final range of college situations, and whether particular colleges remain inside or outside Regional Health Authorities, it is clear that the progressive detachment of existing colleges from health care providers will continue, and it is this trend that presents considerable challenge and threat, and for the best colleges the most opportunities.

Once a college is detached, organisationally, financially and legally from the service providers whose workforce it trains, then it becomes exposed to market forces. In the process of detachment some Regional Health Authorities (RHA) may be inclined to reassure colleges of an element of protection (through for example, the Working Paper 10 (WP10) 'top slice') from service provider units flexing newly autonomous muscle and inclined to charge 'market' rates for space, services and placements. Nevertheless the future dynamic will link stability and success only to the relation between cost and effectiveness. As quality becomes defined in this way, neither
regions or trusts will be interested in established historical relationships or boundaries, and colleges inclined to maintain conventional anachronistic approaches will go into decline. In these circumstances the extent to which a college thrives will be influenced not only by approaches of management but by the attitudes and skills of all its staff. Both will be interdependent limiting factors.

A competitive training environment where colleges work for client service providers demands the adoption of marketing practices by colleges. The essence of marketing concerns the priority of the consumer and all definitions include the implication, traceable back to Adam Smith (1776), that consumption is the sole end and purpose of all production. Although superficially a simple idea, the concept carries profound implications deriving from the fact that a marketing approach necessarily puts the consumer of products and services at the heart of all aspects of an organisation's activities.

Despite an increased profile for marketing in relation to post compulsory education and training (see for example Davies & Scribbins 1985, Theodossin 1989) and increased recognition of the importance of marketing by many educational managers, there is still a widely held inclination amongst education service staff to focus on internal priorities when developing and operating their services. Such internal priorities sometimes involve the ascendancy in curriculum development of philosophical or epistemological commitments on the part of college staff over client needs, or a reluctance to tackle operational issues which appear to favour the status quo. In practice this ascendancy of 'product' over client becomes apparent in a whole range of manifestations from curriculum dogma (e.g. misused concepts of 'coherence' and 'progression' to put unnecessary limits on flexibility) to apparently insoluble logistical problems which limit a response.

In practice marketing involves systematic approaches to the identification and satisfaction of consumer requirements. Although education and training does operate within a range of genuine limiting constraints, many sacred cows will be slaughtered by the scrutiny of competition. In the field of health care education and training, a marketing approach is probably no longer optional for colleges that intend to succeed. In this context, the 'marketing gap' between necessary marketing approaches and the established practices of many colleges presents a threat to their long term solvency.

CLIENTS AND MARKETS

Any attempt at the application of marketing principles and techniques demands a clear understanding of who the clients are. In health care education the situation is particularly complex. Added to the student/employer dichotomy are the complexities of regional contracting for unit/trust training needs. In these circumstances it is important to identify clearly whose needs are the primary concern, and the basis on which education contracting decisions are made. Since regional contracting through WP10 arrangements represents a model of substantial and increasing significance to colleges, this analysis will deal only with that area of college business.

In the general area of professional and vocational training, various authors have given consideration to the significance, in marketing terms, of students and employers. Gray (1989) for example distinguishes between the two by referring to students as 'customers' and employers as 'clients'. Whether or not students are employees, professional education and training must prepare them to fulfil competently a professional role in an employing organisation. Regardless of vocational area, professional courses will at best resolve many apparent conflicts that arise between student and employer need. Whether all such conflicts are in fact real is a moot point. In some cases at least, such apparent tensions arise from ideological and priority differences between educators and employers which can be resolved. Some authors have attempted to clarify the related significance of students, employers and even validating authorities by extending the concept of client beyond any practically useful sense, and there is a danger that such wide definitions can obscure
important realities of the new situation of colleges of health care studies. Furthermore there is a real sense in which success in relation to student numbers will normally follow success in relation to employer satisfaction. Aside from the direct consequences of not meeting employer need on the outcome of education contract bids, a more subtle effect will come to bear on pre-registration college enrolment as potential students choose to scrutinize a college's record in terms of graduate employment statistics.

In the WP10 context it best suits our present purposes to identify employing and contracting organisations as the clients while recognising that in addition to the moral and financial obligations that students represent, and their enormous significance as representing colleges in client areas, their interests will be best served by the more sophisticated colleges whose education services are strongly and accurately derived from service need. This said, we are still however, left with considerable complexity in an area which for marketing purposes needs to be clear.

A client as commonly defined engages or receives the services of a professional person or organisation. This statement exemplifies the problem for colleges, for under current arrangements it is the commissioners of education who 'engage' the college through contracts while it is the NHS trusts and DMU's who effectively 'receive' training and trained personnel. While the typical post-April 1993 funding routes to colleges (Fig. 1) helps to clarify the significance of regions, as the direct source of the major element of college revenue, consideration of funding alone dangerously neglects the significance that NHS trusts and units etc will have on college solvency.

A simpler and more balanced picture is provided in Figure 2 which identifies the key organisations and links with regard to WP10 contracting processes. The diagram consists of a triangle with the RHA at the apex. In fact, since regions set up a group of commissioners of education to which they delegate contract decisions, then the commissioners become effective clients even though they spend on regional budgets. Information relating to the quality of education provision flows (often at present in rudimentary form) to region from both the service providers and the colleges.

Although the detail of information from colleges to region varies, it typically involves regular contract monitoring returns and an annual evaluation process of some sort. Whatever the exact nature of the information, it is highly likely that all colleges will be careful to provide regional commissioners with a positive perception of their education services. With all colleges representing themselves in the most positive light; in order to make sensible contracting decisions, the commissioners will increasingly be dependent on the views of units and trusts to distinguish real from alleged quality. The possibility of regional delegation of the commissioning role to consortia of trusts and units further strengthens the contracting influence of service providers — indeed it would make them the sole clients. Regardless of the present level of sophistication within service provider units as regards the evaluation of education, it is clear then that either through influence or actual commissioning they are key players in the future of colleges. In this context the flow of information along the base of the triangle (Fig. 2), which represents the totality of the relationships between college and service providers will in all probability be the ultimate determinant of whether colleges thrive or struggle in the new training environment.

QUALITY AND THE ROLE OF THE COLLEGE

It is important for colleges to formulate a concept of quality which accommodates the clients on which they depend. A key element in any client sensitive concept of quality will be the match between needs and provision. This apparently simple relationship represents the heart of the marketing idea. Although many colleges would claim a good match, it is very often less apparent to the outside observer than they might think. Current practice appears often to relate provision to needs as perceived in the minds of curriculum developers rather than actual needs,
as perceived by the clients. In these circumstances some colleges appear to be taking the dangerous route of neglecting certain types of need which are of real significance to the clients, relating for example to the relationship between cost and effect and the extent to which placements and mentorship draw resources from clinical areas.

No amount of 'liaison' with service providers can overcome the baggage in the mind of a curriculum developer who 'knows' rather than actively searches out the service provider needs in a systematic way. In such circumstances the internal evaluation of quality by colleges can become no more than a modern day analogy of Nero's fiddling. In these cases service providers' reports to commissioners when they become sufficiently articulate will not be corroborating the colleges own view of its performance.

With some such concept of quality developed in the college, the processes of achieving it can take a range of forms (e.g. Sutcliffe & Pollock 1992) but from a marketing standpoint evaluation must scrutinize:
The identification and articulation of service needs.

- The acknowledgement of these needs in curriculum development.

- Provision for these needs through the curriculum in operation.

The strongest colleges will be skilled and involved in all these activities including participation in service needs analysis. In this way a college will be able to apply a complete range of training-related skills to the benefit of service providers. By helping clients with needs analysis, college will achieve the insights not possible through less focused liaisons. It can then apply curriculum development expertise to produce highly relevant professional curricula with local focus and national recognition.

This composite of skills from needs analysis to education and training provision represents a set of services to units and trusts which constitutes a strong foundation for the myriad of contacts that represent the base of the triangle (Fig. 2).

Furthermore these processes could provide for a direct training-led perceptible effect on quality of service which could be assessed directly by the evaluation of training effects on service quality as part of course monitoring.

Depending on the nature of the existing relationship between a college and its clients, among other things, service providers will vary in the extent to which they are inclined to look to their local colleges for training services. As a knee-jerk response to their own increasing powers many will be inclined to employ their own trainers, (bringing some training back to an in-house situation) and some will show a reluctance to enable colleges to get involved with such things as training needs analysis (in favour sometimes of independent consultants). These two responses are already apparent among units and trusts and to some extent demonstrate a degree of scepticism and uncertainty with regard to colleges' abilities (and indeed inclination) to deliver in response to their needs.

The only effective way through these issues...
for colleges is to establish a pattern of services for clients in which the cost-benefit relationship is such that a strong and maintained relationship with the college is clearly advantageous. In order to assemble such packages, colleges will need to develop an empathy with units and trusts which enables them to understand and assimilate the client's own perceptions of need.

Whereas many colleges have good links with service areas nurtured through link-teachers, lecturer-practitioners, advisory groups etc, these links are often not used to good effect in marketing terms. Not surprisingly, unused to the new position, many nurse tutors while highly skilled as sources of expertise and facilitators of learning, are less able as expert listeners and observers who can contribute, through the design and operation of training programmes, to the satisfaction of client needs.

For most of those who desire to possess them, the skills of working for clients are reasonably attainable; the inclination to accept the new circumstances however is more of an issue at present for most colleges. Only when a college's culture shifts from in-house training to a marketing approach will it be able to begin to grapple effectively with the new challenges. With a combination of empathy, expertise, quality and awards, most colleges should be able to survive by assembling a package of services and charges of interest to units and trusts. Where work is in fact better carried out in-house (i.e. the relationship between cost and effect is more beneficial to the client) then colleges can facilitate the quality and appeal of such programmes through accreditation and other means which enable a client under financial constraints to maintain a coherent approach to training.

Whatever the defining attributes of the quality concept adopted by a college, it is important that references to 'excellence' are backed up by explicit and widely appreciated ideas of fitness for purpose and the relationship between cost and effect. These should take a greater emphasis alongside the more conventional values still very necessary in the health care field.

Through all such changes of approach and attitude, a challenge for colleges will be to maintain intellectual and professional demand on students and the rigour in assessment necessary to maintain the general standard of programmes and the consequent integrity of the awards. Working for clients is not about simply complying with their wishes. Despite the rate of change, most clients and colleges will continue to work together with a degree of stability, (losses and gains of business will in most cases be incremental rather than catastrophic – not least because of the length of programmes) and in this context, colleges will need to establish the type of relationship where creative solutions to difficult problems emerge. Apparent tensions between costs and standards; local focus and national creditability etc will need to be solved with both rigour and imagination.

THE NEW CURRICULUM

The need to improve the match between employer need and vocational curricula is not new. While the non-advanced further education sector has been encouraged for some time to become more responsive to employment needs (see for example, Cribb, et al 1989), higher education is, particularly through the development and operation of credit accumulation and transfer schemes, recognising a changed role in the continuing education of professionals (see for example THES 1992).

Health care education however will need to take these ideas further. The extent to which control by local employers of very large training contracts on which a college (or faculty) is effectively dependent, represents a unique situation which existing models of response can only partially accommodate. Even more serious however is the mismatch between the curriculum theory paradigms which prevail in colleges of health care and the sorts of marketing approaches that the new situation demands.

While units and trusts increasingly express concern over the relevance and costs of conventional health care education, many nurse tutors, in the absence of any real alternative practise curriculum development in line with anachronistic but still prevalent methods. While health
care itself has shifted to a client-centred stance, health care education struggles with a conventional system of values, beliefs and practices. A nurse tutor for example, resorting to standard texts on curriculum and curriculum development will find little or no guidance on marketing in relation to curriculum design and, despite some theoretical consideration of instrumental or utilitarian curriculum models, no mention of clients.

Yet the situation in health care education now demands a sophisticated theoretical synthesis capable of resolving marketing and the more valuable elements of conventional curriculum theory. In the creation and testing of such a model, health care education could establish a new curriculum paradigm and approaches to curriculum development of wider interest in the field of vocational higher education. In any event curriculum paradigms which do not consider vocational derivation in both theory and practice as thoroughly as learning process and epistemology, will become increasingly destabilised as the basis for health care education.

Similarly, orthodox approaches to validation and quality control generally may no longer be appropriate. Already credit schemes applied to professional training achieve levels of response which effectively require validation of internal quality systems, rather than content. Many precedents in the field of post-experience professional training are now established. Examples include schemes enabling substantial elements of individual experiential learning to be acknowledged (e.g. Hall 1989) and/or the achievement of all or most learning during accredited provision, either in partnership with (e.g. Allen 1990) or external to (e.g. Walker 1992) the awarding institution. In the latter scheme, participants’ learning may involve attendance at a range of provisions offered by numerous centres of clinical expertise throughout the country.

Designing and delivering the local relevance, flexibility and responsiveness that the new curriculum demands will have implications for all aspects of colleges’ operations. The organisational structure of colleges should facilitate the dialogue crucial for developing services. Superficial efforts at client liaison such as consultative groups, need to be underpinned by managerial structures which complement, reflect and ‘cover-off’ all significant elements of client organisations from trust chief executives through clinical directorates etc, to ward and community staff. In the resulting information rich environment, operating decisions will normally best be made close to the point of implementation. Consequently the system of deploying resources within the college should give maximum flexibility to operational managers (Whalen 1991 argues persuasively for a decentralised approach).

Regardless of these and other characteristics the most important feature of a college will be the skills, attitudes and inclinations of its staff, amongst whom will be those directly involved in the work of developing and operating curricula. Those colleges whose staff assimilate the implications of the new competitive training environment and who collectively develop the composite of skills and approaches that it demands should be able to maintain a significant if changed role in health care education. The best of these may have the opportunity to rewrite the textbooks of curriculum development and establish new approaches to vocational higher education of interest and significance across the post compulsory sectors of education and training.

Acknowledgements

Thanks to Philip Basford of the Thames College of Health Care Studies for allowing Figure 2 to be based on his original.

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Health Care Education

THE CHALLENGE OF THE MARKET

Edited by
John Humphreys

and

Francis M. Quinn
Table 0.1  Diagrammatic representation of the structure of the book in relation to its main thesis

<table>
<thead>
<tr>
<th>Chapter</th>
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<tr>
<td>1</td>
<td>Establishes the main thesis of paradigm change in Health Care Education</td>
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<td>2</td>
<td>Considers the orthodox paradigm and its problems</td>
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<tr>
<td>3</td>
<td>Provides evidence of change through case studies which demonstrate inconsistencies with the established paradigm</td>
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<td>6</td>
<td>Provides analysis of the causes of change and effects on college structure and management</td>
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<td>9</td>
<td>Articulates elements of a new paradigm including a new model for curriculum development implicit in current innovative education practice</td>
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For help with the production and editing of the manuscript, we must thank Jan Borders of the University of Greenwich.

It would be conventional at this point to thank our wives, but in fact they have successful careers of their own and are much too busy to spend time helping their husbands figure out the esoteric complexities of health care education. However, making them cups of tea has sometimes helped clarify our minds.
Editors' introduction

In this chapter the concept of paradigm destabilization is applied as a metaphor for the educational revolution consequent upon the introduction of market forces into health care education. The status of UKCC Project 2000 as a radical educational reform is discussed, and the basic thesis of the book is defined.

INTRODUCTION

In 1962, Thomas Kuhn published his seminal work on the structure of scientific revolutions. In it, he argued that philosophers of science had been misled in their analysis of the nature of the endeavour. In contrast to the then conventional view of science as objective reality assembled through disinterested experiment, Kuhn, through historical analysis, saw only communities of scientists acting like human beings. They were often reluctant to change their ways, precious about their theories and inclined to dogma. Most of their time was spent trying to solve puzzles set in a dominant conceptual framework of received beliefs which the community acknowledged as supplying the foundation for its practice. These received beliefs he called the 'paradigm'. It enshrined values, methods of work and fundamental concepts which provided the basis of explanation. The dogma of the paradigm, he claimed, is maintained through social pressure and education. If someone discovers or does something inconsistent with the paradigm, it is normally considered the problem of the individual, not the paradigm. Perhaps the experiment was flawed or the technique inaccurate or maybe the scientist wasn't quite up to it. Inevitably the quality of the work is questioned. In any event, no scientific group could practise its trade without its received beliefs and, in this context, education and training must initiate the new recruit into the
TOWARDS A CORPORATE PARADIGM

Paradigm. Textbooks serve their purpose by focusing on achievements which support the paradigm. What point is there in disseminating those data which, since unexplainable, must clearly be problematic?

From time to time, however, something may destabilize the paradigm. Perhaps an unavoidable accumulation of evidence apparently refuting central tenets. Perhaps a moment of new insight amounting to genius. Such events must be enormously persuasive since the defence of the paradigm is strong. After all, careers are at stake; strongly held values are questioned and dogma is more reassuring than confusion. Such events imply radical change and Kuhn therefore identified the replacement of one paradigm with the next as 'revolution'.

Since its publication, Kuhn's work has been widely discussed, widely applied and widely misused. In this chapter, we will probably misuse it a bit more. However, we will not do this naively. Kuhn's ideas concern science, an endeavour which is different from and conducted in a less complex environment than health care or health care education. We do not therefore claim any direct correspondence between the two, but we do recognize some analogous situations, and from them some insights that we wish to bring to bear on the current state of health care education.

In the first place, Kuhn's work carried a technical definition of revolution which we find useful. Revolution in the sense that we use the term need not be fast (although often it will be) and may not generate much interest outside the professional community (although it may receive press coverage). But it must be radical and therefore, to a large degree, incompatible with what went before. In this way, we can distinguish between reform – in which what went before is remoulded (or reformed) – and revolution in which new methods, concepts and even values (collectively a new paradigm) replace earlier ones with which they may have little relationship. Our revolution then is simply a fundamental change which has, and is, radically shifting the practice of health care education.

Although wide-ranging in its coverage, the central thesis of this book is that a set of established values, received beliefs and methods of operating are in the process of being overturned. Since we regard these values, beliefs and methods as, to a degree, dogma, we are drawn to a Kuhnian analogy. Essentially in health care education, a long-standing curriculum paradigm is being deserted by educational practitioners.

Kuhn showed that what might be called professional communities can operate in ways less idealistic than they sometimes claim. Commonly scientists, while believing fervently in objective truth, in fact sacrifice this high ideal to a dogmatic commitment to favoured ideas. If scientists can do this type of thing, then so can health care professionals and so can educationalists. In those interim (revolutionary) periods between paradigms, Kuhn described practitioners arguing vehemently for one or the other side. In fact, in these communities such changes can provoke severe criticism by practitioners of the work of contemporaries. In education we perceive current debates relating orthodoxy to 'standards' as one of many manifestations of this interim period.
Kuhn's concept of paradigm was somewhat problematic from the start. Masterman (1970) found that, in introducing the idea, Kuhn had used 'paradigm' in at least 21 different senses. Since 1962, the idea of paradigm has received abundant analysis which it is not our intention to review here. Suffice it to say that Kuhn's paradigms have been extrapolated beyond their scientific origins across a range of intellectual endeavours. Although still problematic in various respects, there is no question that Kuhn's ideas on paradigms and revolution have proved useful in analyses of the development of ideas and the behaviour of communities of practitioners beyond those working in the sciences.

However it is by no means clear that the original Kuhnian concepts of paradigm and revolution always apply. The general Kuhnian progression may not, for example, apply where there is no universally accepted paradigm to overthrow (Bottomore, 1971, argued this of sociology). Sociologists can also argue that there was little originality in Kuhn's views of education. Education as a process of socialization is not a new idea; Simpson (1967), for example, showed how pre-registration nursing courses effectively socialized new recruits into the profession (Chapter 9).

Before committing ourselves to paradigms for the purposes of our book, we must ask the question as to whether health care educators as a professional community do in fact hold a paradigm that fairly universally informs their practice. Schein and Kommers (1972) made a distinction between the practice of professions and the theoretical paradigms which underpin practice. In doing this they distinguished between professions, which they considered to achieve a high degree of consensus on underlying paradigms (engineering and law) from others in which consensus was not apparent (teaching and clinical psychology).

We consider such analyses to be anachronistic in that they imply a fairly static interface between theory and practice in professions, which the work of Schon (1991) and others have shown in fact to be a dynamic and fuzzy distinction involving a considerable degree of interaction. For our current purposes we would like to postulate that professions can operate on the basis of paradigms of practice rather than simply practice on the basis of underlying theoretical paradigms. Such paradigms of practice may be compatible with a range of theories, models, etc., but carry certain fundamental value and method commitments. This point is considered further in Chapter 2.

A perennial problem with paradigms is that, whereas many consider them a useful idea, once an attempt is made to describe one in any definitive way the difficulties originally identified by Masterman reappear. A recent example of dispute over what is or is not a paradigm can be seen in the area of social psychology. In this case Harre (1993) has defended his position that a paradigm shift has indeed occurred in social psychology (challenged by Farr, 1993) by referring to Fleck's original expression of 'thought style' from which Kuhn derived his idea of the paradigm. Fleck used this phrase to indicate an idea of commonality in a more loosely structured field than paradigms have come to represent.
Since there is a danger that such disputes would be a hindrance (and peripheral) to the main purpose of this book, we will sidestep the issue by arguing analogy with, rather than correspondence to, strictly Kuhnian paradigms. Essentially we have found Kuhn's insight illuminating in our analysis and although our paradigms may be better described as 'thought styles' in fact the more we consider the manifestation of change the more we are drawn back to Kuhn.

As Mulkay (1991) observed, Kuhn's paradigms imply an endeavour characterized not by intellectual openness but by the intellectual closure of practitioners who, while they may generate and discuss many theories and models, rarely bring into question basic assumptions. Chapter 2 reviews some of the

| Table 1.1 Some features of two conflicting paradigms of health care education |
|---------------------------------|---------------------------------|
| Destabilized orthodox paradigm  | Incipient new paradigm          |
| **Primary concerns**           |                                 |
| 1. The profession              | 1. The corporate organization   |
| 2. The patient                 | 2. The student                  |
| **Ideologies**                 |                                 |
| Various                        | Instrumental                    |
| **Values**                     |                                 |
| Patient as client of education | Employer as client of education |
| Student as moral responsibility| Student as consumer             |
| Education as entry to profession | Education for strategic development |
| Student as putative professional | Student as workforce supply     |
| Education as in-house          | Purchase/provider split         |
| Quality as intellectual        | Quality as fitness for purpose  |
| rigour                         |                                 |
| Curriculum as established      | Curriculum as product           |
| practice                       |                                 |
| **Methods of Work**            |                                 |
| **Curriculum derivation**      |                                 |
| Professional regulation        | Market demands                  |
| Epistemological analysis       | Training needs analysis         |
| Education-led curriculum       | Market-led curriculum development |
| development                    |                                 |
| **Process**                    |                                 |
| Teacher as socialization agent | Teacher as change agent         |
| **Fundamental concepts**       |                                 |
| Courses                        | Flexible learning programmes    |
| Coherence (as internal to course) | Coherence (as internal to students) |
| Progression (as unshrined in specified sequence) | Progression (as internal to students) |
CAUSES OF CHANGE

Theories and models of curriculum commonly used by health care education and identifies an underlying assumption implied by their consistent neglect of employers. Yet for many practitioners of health care education, employers are now seen at the very centre of their activities (see, for example, Chapter 8). From our consideration of these two stances (reviewed in Chapter 9) we have identified two distinct 'thought styles' or paradigms, one orthodox and one new.

Table 1.1 summarizes our view of some aspects of the old and new paradigms. We position it here as an 'advance organizer' (Ausubel 1978) for the book but we will leave our detailed arguments until later (especially Chapters 2 and 9). Since we argue a current intermediate stage, neither paradigm is considered to correspond exactly to the existing situation. In the current confusion, elements of both paradigms are manifest (we hope the case studies illustrate this point).

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Textbooks can give us clues (we would not say evidence) as to the possible causes of the radical changes. In this respect omissions may be most important. We have so far failed to find a textbook of health care education that gives any serious consideration to the new employers of health care professionals. Even recent publications in educational journals or from statutory bodies consistently neglect NHS trusts; and from some publications it would be difficult to believe that they exist. Yet it is inconceivable that authors or statutory bodies are unaware of the significance for education of NHS trusts. In our view, this apparent inability to make the connection between employers and professional education reveals an inability of the existing paradigm to accommodate corporate-style employers. While such organizations increase their power and influence, the curriculum paradigm precludes anything but a superficial response. As the mismatch increases, so practitioners of education are deserting the established paradigm and so innovative case studies become inexplicable in conventional terms.

Over the last few years, a major preoccupation of health care educators has been the introduction of 'Project 2000' (UKCC, 1986) courses for the initial training of nurses. These courses differed from previous ones in that students became pre-service rather than in-service (i.e. when in clinical placement they were supernumerary to the necessary workforce). Additionally P2000 courses lead to higher education qualifications whereas most earlier pre-registration training had not.

The extent to which this development has dominated the minds of nurse educators is reflected by the avalanche of analyses and reports which are now available in the literature. However, in the context of professional education generally, P2000 does not constitute a radical reform. In identifying nurse education as higher education, and students as supernumerary, P2000 simply
brought nurse education into line with the education of many other professional
groups. Although representing a real challenge to health care education
providers, there are few new educational principles implied or enshrined within
it. Although often represented as a highly significant educational reform, the real
significance of P2000 is not to education but to the profession. It constitutes
more than anything a reform of the profession of nurse. Through orthodox but
changed education, P2000 has identified the nurse as different from before. It
has profound implications for her/his position as a practitioner and in relation to
other workers in the clinical environment. By virtue of its explicit link with HE
awards, P2000 has recognized and consolidated the nurse’s position as a ‘profes­
sional’ practitioner. It is, in short, an education-led reform of the profession of
nurse and, although it radically changes the profession and raises many clinical
and employment issues, solutions to the educational challenges of P2000 can be
abstracted from many precedents, parallels and precursors in the domain of pro­
fessional education. Seen in isolation P2000 may be radical for the profession,
but in education terms it is not in itself revolutionary.

The true educational significance of P2000 is revealed when it is considered
in the context of NHS reorganization. In order to create the internal market for
health services, district health authorities (DHAs) have undergone a change of
role. Whereas previously health services were provided by ‘units’ within DHAs,
these units are now becoming independent NHS trusts. This enables Districts to
take a role in the purchasing of health services (on behalf of patients) from NHS
trusts. This purchaser–provider split constitutes the main element of the market.
Since all transactions fall within the scope of the Department of Health, the
market is considered to be ‘internal’.

These general NHS reorganizations posed various issues for education. In the
event, regional health authorities were given the initial responsibility for funding
education through a process originally published by the Department of Health as
Working Paper 10 (WP10). At this point the position of DHAs in relation to
education became ambiguous. With colleges located within DHAs, districts
were essentially providing regionally funded education services for those trusts
from which they were purchasing health services. The anomalous nature of this
position had, because of P2000, a ready-made solution. P2000 had driven col­
leges into close links with higher education. With strong links already devel­
oped, it therefore became inevitable that many colleges would incorporate into
universities. After some prevarication, the NHS ruled out most other options
and, at the time of writing, the process of incorporation of colleges into univer­
sities is widespread.

Thus, in the spirit of health service reorganization, an incipient market for
education positions regional health authorities as purchasers of education ser­
vice from higher education institutions. Unlike the internal market for health
care provision, the education market has been created through the combined
effects of relatively unrelated policy decisions, driven by much larger financial
and other imperatives of NHS reform. Furthermore the education market lies
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across government departments and is therefore, for the moment at least, not entirely 'internal'.

Educational change, therefore, has been a consequence of larger reorganizations rather than any single coherent policy. In creating links between health care education and universities, P2000 provided a ready-made solution to an education problem posed by NHS reform, and this synergistic interaction between P2000 and NHS reorganization resulted in an education contracting system for which (as Chapter 7 argues) there are no precedents.

Paradoxically, then, we have the situation where P2000, much discussed as an educational reform, in fact carries limited educational novelty, while general NHS reform carries revolutionary implications for education. This book is about a revolution in the practice of health care education driven in the last analysis by the reorganization of the NHS.

For our present purposes a revolution can be considered to involve three distinct although chronologically overlapping elements - first, the established or orthodox paradigm; second, an interim period of relative confusion; and third, a new paradigm. We believe that there is now evidence of a significant departure from orthodoxy. Chapter 2 includes an analysis of this orthodoxy and asserts its demise. Chapters 3, 4 and 5 describe case studies, each of which illustrates a significant departure from earlier practice.

We also believe that health care education currently occupies an interim position in which the practice of education is more variable and volatile than before. This position seems an almost inevitable consequence of complex interactions between the different issues that health care education is currently addressing. On the one hand the move into higher education is in some institutions raising the prospect of academization, led by those universities more committed to theory than to professional practice. Meanwhile increasingly confident NHS trusts look for an educational contribution of skilled and reskilled practitioners to progress their strategic development. Somewhere between these two corporate sectors, statutory and professional bodies can be found trying to reconcile their twin desires of graduate status and professional focus – and of course these things are not incompatible.

We do not claim to know exactly which way things will go over the next few years. A critical factor will be the long-term location of the control of education funding and in particular the ways in which the market for education is managed. However, already some things have gone beyond the point where they can easily be reversed. On one side of the education market there are now NHS trusts and on the other (increasingly) universities. These two influential, independent and corporate sectors therefore represent the beginnings of a new stability in our otherwise changing educational environment. In these circumstances education would appear almost inevitably to be moving towards what we will call a corporate paradigm. This movement is the subject of our book.

Policy changes in education and training may create various dilemmas for education practitioners. While on one level they may need to review aspects of
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their current practice to anticipate or better accommodate the new environment, on another, conflicts may arise with regard to the moral and/or political issues that such changes may raise. The purpose of this book is not to address the latter issues. In particular it does not attempt a critique of the new situation and indeed we have avoided adopting any particular moral or political stance. Although we certainly hope to provoke a debate, we believe that a full critique should follow research into the actual effects of the new environment on education and its effectiveness.

Although in due course we intend to address the moral and political issues raised by these developments, our present purpose is simply to describe, analyse and inform, and in so doing to help practitioners of education address the practical dilemmas and challenges that the new environment creates.

REFERENCES

The position of the corporate college

Bill Bailey and John Humphreys

Editors' introduction

This chapter begins an analysis of the nature and implications of the new market for education, which constitutes most of the second half of the book.

By examining three ‘key transactions’ of colleges, namely money, students and trained personnel, the chapter shows how the conventional ‘in-house’ training of the conventional DHA college is being superseded by a market situation in which both the college and the college’s primary clients (NHS trusts) are corporate organizations.

A comparison of the position of colleges of health care studies with institutions of further and higher education in England and Wales is used to show that colleges are moving from unusually secure positions within health districts to uniquely exposed positions in which their future solvency is increasingly dependent on small numbers of similar and powerful employer organizations.

INTRODUCTION

Changes of status, management, resourcing and curriculum are currently affecting schools of nursing and midwifery. Institutions of further education and higher education are also experiencing changes in these areas – mainly as a consequence of the Further and Higher Education Act 1992. This chapter compares these changes with the intention of identifying the principal similarities and differences, in particular drawing out the important implications for those involved in health care education.
In its intention and implementation Project 2000 has constituted a major change in the education of nurses. The linkages the colleges have established with higher education institutions and the opportunities presented by the supernumerary status of students have enabled course teams to develop new programmes for those intending to nurse. However, these educational developments, seen by the nurse educators as central in the discussion and development of new Project 2000 courses, have now been superseded by the government's continued measures aimed at establishment of a 'market' in the National Health Service. A part of this further development has been the introduction of a market in the provision of education and training for health care workers. It will be argued that this second wave of changes will affect the working of schools of nursing (faculties of health care studies) more radically than the first period of curriculum development.

THE TRADITION

Historically, health care education and training has been the task of the schools and colleges which have been one part of a larger organization (the 'District') and providing professional and training services for that organization. This has taken the form of relatively small units enjoying a stable and secure position within the 'parent' organization, the District Health Authority (DHA). These schools and colleges have been perforce largely monotechnic institutions. The fact that, in some cases, districts have shared schools or colleges did not significantly alter this familiar model of organization. Figure 6.1(a) represents this situation where the district health authority owns and resources its college. In this, all the important movements, or transactions – of money, trainees and trained personnel – are internal ones. What is more, all the staff involved, managers, tutors and trainees, are employees of the district health authority. In these circumstances the college was an important part of its larger organization; it had no separate, legal existence, a feature important to those negotiating the merging of colleges into higher education institutions.

It is illuminating to contrast this traditional form of organization with that found in public sector further and higher education in England and Wales prior to the Education Act 1988. Figure 6.1(b) shows the position then of further education colleges and polytechnics. Like colleges of health care studies they effectively formed part of a larger organization, in this case that of the local education authority (LEA). Typically, their costs formed a relatively small part of a large total budget. As in the case of colleges of health care studies the assets (buildings and equipment) were owned and the staff were employed by the parent organization. At this point a difference emerges, since only money moved within the organization – from the LEA to the college or polytechnic. Although there were complexities in the organization of both types of institution – those providing further and higher education (FHE) and the health care institutions – the basic financial reality for both was that their main source (or
Figure 6.1 Comparison of the position of colleges of health care education and colleges of further education prior to reorganization of the two sectors. Square boxes represent self-contained ‘corporate’ organizations whereas ovals and circles represent groups with no legal independent status. Arrows indicate the educational relation between organizations and groups with regard to the three ‘key transactions’ of money, students and trained personnel. (a) shows the position of colleges of health care education prior to NHS reorganization and (b) shows the position of colleges of further education prior to their reorganization in April 1993 (at that time, polytechnics were in a similar position to further education colleges).

supply) of resource was the large ‘authority’, the LEA or the DHA, to which they literally belonged.

This is not to suggest that all financial resources for FHE institutions were raised locally. Some monies were raised in the form of locally levied rates but a large proportion were distributed by central government in the form of the rate support grant. There were differences in the system of aid to further education colleges and polytechnics. Resources for distribution by district health authorities to colleges of nursing derived from funds from the Department of Health.

We do not suggest that this state of affairs necessarily represented stability for the two kinds of institution and their staff. They were, for example, both subject in some cases to amalgamation and difficulties caused by cuts in resources
because of the LEA's or DHA's budget problems. Also, the principals of the institutions could be heard protesting about the restrictions on their activities which they saw as deriving from their low status as the creature of larger organizations or systems. In general, though, Figure 6.1 summarizes circumstances which in certain ways benefited the two kinds of institution. Both LEAs and DHAs saw it as to their advantage to support their colleges, to keep their staffs usefully employed; and they took some pride in the development of 'their' institutions. Certainly, they did not seek to create situations that would lead to staff redundancies or redeployment, and the financial costs and loss of morale to which these would lead. There is, however, an important difference to be identified between the two sets of institutions. While further education colleges and polytechnics have always depended on attracting enough (usually, more) students each year, across a wide range of specialist areas, colleges of health care education have been dependent on a single industry.

As was stated earlier, the colleges of nursing can be seen as monotechnics having a clearly articulated relationship with their parent organization, the DHA, which in turn is the employer of their output of trained and qualified personnel. They are dependent on these in a number of important senses — for resources, for placements and for the employment of their successful trainees. The colleges in the further and higher education sector are not dependent in this way, for two important reasons. Firstly they draw students from the community at large in which the demand for courses continues to grow. Funding policies in the past have generally encouraged these institutions to recruit more students; this has been done through a reflection in its annual budget of increases in student numbers achieved by the college during the previous year. This growth has been possible because further and higher education colleges are polytechnic institutions. In turn this means that, as demand for courses, from employers or from students, has changed, they have been able to adapt their provision to that demand. In further education colleges this can be shown in the growth of GCSE and GCE A Level enrolments as vocational departments have shrunk as the result of the decline of industry during recession. This sort of response is not open to colleges of nursing whose work is dependent on a much more restricted client group. The polytechnics have similarly expanded during the last decade in response to demand from increased numbers of qualified school-leavers and adults — notably in faculties of humanities, social sciences and business studies. In brief, the public FHE colleges have always existed in a complex market situation. This is in strong contrast with the historical situation of the colleges of nursing. Furthermore, in the context of limited opportunities for re-emphasis or diversification, colleges of health care education are being exposed to competitive contracting-funding directly with the monopoly purchasers of their service. This constitutes a situation which has never been faced by public sector colleges.

While it appears to be difficult to find any parallel for the security (indicated by the key transactions in Figure 6.1(a)) enjoyed until recently by the health care colleges, it will be argued below that, in the new market environment that the
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government seems determined to impose on the health service, the colleges/faculties of health care studies will be confronted by more challenging circumstances than those experienced in 'mainstream' further and higher education.

THE INDEPENDENT FUTURE

Although the future of colleges of health care studies may take one of several forms, the implementation of Project 2000 has led to circumstances in which, for most colleges, the future lies within large independent corporate organizations whose business is higher education. The essence of a corporation is its separate legal existence which enables it to enter into contracts with other organizations. The corporation bears responsibility for the efficient and legal conduct of the institution's affairs and is legally empowered to act as if it is an individual person. Like other, more familiar, corporate bodies, higher education corporations own their assets (buildings, land), employ their staff and can accumulate cash reserves. They can prosper or they can fail.

During the last few years the public sectors of first, higher education, and then further education, have been 'incorporated'. In the case of the polytechnics and colleges of higher education this change followed the passing of the Education Act 1988. This Act removed the polytechnics and other colleges whose main work was higher education from their local authorities and set up a Polytechnic and Colleges Funding Council (PCFC) which took over responsibility for the planning and financing of public sector higher education. For the 'old' universities the Universities Funding Council (UFC) was formed with a constitution and role similar to those of the PCFC with respect to its institutions. The aim and effect of these decisions was to reduce the influence of local education authorities (Maclure, 1989). The Government believed that, if decisions on the allocation of courses and resources were taken nationally, the institutions, 'freed' from their local education authorities, would become more businesslike and enterprising and so would take up opportunities presented by the funding council and the world of industry and commerce. The Further and Higher Education Act 1992 rationalized the situation in higher education by creating two Higher Education Funding Councils, one each for England and Wales, which replaced the UFC and the PCFC. Also, the polytechnics and some colleges of higher education became universities.

The 1992 Act was important also for the statutory decision to remove the further education colleges from their local authorities and to give them the same corporate status as had been given to the polytechnics after 1988. Again a new national funding council was established, the Further Education Funding Council (FEFC). This Council (itself incorporated) is charged with a broad remit: principally, to assist the colleges in raising participation rates of 16–18-year-olds and to promote the quality of further education programmes as they contribute to the achievement of National Education and Training Targets. The FEFC
supported the Colleges as they prepared for their new corporate status which they assumed on 1 April 1993. Their position with regard to the transactions we have identified can be represented as in Figure 6.2(a). That position is, given the historical diversity of the further education sector, more complex than that of the universities – or of health care colleges. While the bulk of the funding for

![Diagram](a)

**Figure 6.2** Comparison of the positions of colleges of further education and universities with colleges of health care studies after reorganization of the two sectors. Square boxes represent corporate organizations, whereas ovals or circles represent groups with no legal independent status. Arrows indicate the educational relationship with regard to the three key transactions of money, students and trained personnel. (a) shows the position of further education colleges and universities and (b) shows the position of colleges of health care studies.
further education colleges comes via the FEFC (out of money previously spent by LEAs on their colleges), there are other sources of finance. The chief of these are the Training and Enterprise Councils (TECs) which agree (i.e. contract for) the provision of some work-related courses in colleges, as well as Youth Training and Employment Training programmes. Some colleges receive finance from the European Social Fund (ESF) for agreed projects and many put on ‘full cost’ tailor-made courses for local companies and organizations. Additionally, it should be recorded that the FEFC in the first year of its existence took on responsibility for the allocation of PICKUP funds (for professional and industrial updating) and for ACCESS funds to further education colleges.

In summary, the years since 1988 have seen radical changes in the organization and funding of public sector higher and further education institutions in England and Wales. Each institution now operates as a corporation and is independent in the sense that it is in charge of its operations and can make decisions about its use of its resources, physical, financial and human. Colleges and the universities now receive their allocation of funds from national councils which distribute the government’s allocations of monies for FHE according to (changing) methodologies based on views of national ‘needs’ and to some degree on an assessment of the quality and efficiency of the service provided by the institutions. In 1993, for example, the HEFC for England decided to reduce funding for students on arts and humanities programmes in an attempt to steer institutions towards more vocationally useful science and technology courses. The FEFC, on the other hand, is still, at the time of writing, consulting with the colleges on a new funding methodology. What is clear is that it will not be a simple allocation based on ‘entry’, i.e. based on numbers enrolled on courses and programmes. It will reflect colleges’ abilities to retain students ‘on course’ and the achievements of students at the point of ‘exit’ (their accreditation by examining and validating bodies). Both the further and higher education sectors have seen significant increases in student numbers over the last five years – despite the decline in the size of the age groups caused by demographic factors, but also the result in part of the economic recession. A significant proportion of this expansion has been achieved by increased efficiency rather than new money.

Although there are alternatives, present evidence suggests that most colleges of health care studies will be incorporated into large higher education corporations: that is, into ‘old’ or ‘new’ universities. In these circumstances, their position as far as important transactions and movements of resources and students are concerned will be very much the same for the purposes of this comparison. Figure 6.2(b) shows the position of colleges as they separate from the district health authorities. Since the DHAs have no longer any direct role in education and training they are omitted from this figure. It will be seen that all the key transactions now involve interaction with bodies or institutions external to the college. Students are/will be recruited from the community at large and enrolled as supernumerary pre-registration nurses on Project 2000 courses or they will
come from NHS trusts, which will also be the future employers of newly trained personnel. The situation in which the college is placed is that of a market, in which it will have to compete with other similar organizations to obtain contracts. Its success in obtaining such contracts for initial and post-initial training will determine its solvency and, therefore, its survival. In this market situation, no health service organization (RHA or DHA) is financially responsible for protecting a college if it fails to secure funding by contracts. This will be the case even if the college forms a faculty of a university, since the university will be reluctant to use what are likely to be limited cash reserves to subsidize loss-making operations. Also, both the internal politics and auditing procedures of the universities will be likely to prevent funding council allocations for students on other programmes being transferred to ailing health care faculties.

In this new era the unique situation of the health care faculties is likely to become clear. Unlike the corporate further education colleges and universities generally, who are working to national funding councils which are charged to increase numbers of students on courses, the reorganized health care faculties will depend for their future funding on contracts competitively allocated by a limited number of service providers. The role of the RHAs in relation to Working Paper 10 (WP10) is to spend to ensure 'regional self-sufficiency' in terms of the supply of trained personnel and their in-service training. There is no reason why regional health authorities should recognize traditional DHA boundaries by contracting with the college which has historically provided training for a DMU or NHS trust. We can extend this argument and speculate that, provided adequate and good quality training is offered, the regions could contract with successful colleges outside their area. These could, for example, provide some of the training by means of distance learning methods and, for direct teaching purposes, lease local premises.

In this competitive climate, the colleges/faculties will be scrutinized for quality and cost-effectiveness in ways they have not experienced hitherto. Furthermore, as purchasers of education become increasingly aware that they are spending resources on behalf of service-providers, a situation without precedent in professional or vocational education is likely to emerge. In Figure 6.3 we represent the situation where RHAs establish consortia of service providers to make decisions on contracts for education and training.

In these circumstances, although WP10 moneys technically flow from the RHA to the colleges, the consortia make the contract decisions. It is they, the consortia, which have effective control of the colleges’ money supply and, therefore, their solvency. It can be seen that the key transactions, again of money, students and trained personnel, take place between a college and the service providers with whom it is contracted to provide training. Since they become effectively the direct purchasers and receivers of training, the consortia are (or will be) critically important clients uniquely positioned to determine a college’s future. While some RHAs may intend to secure colleges during a period of transition, in order to give them time to adapt to the new context,
others will not. Already in some regions all education and training contracts are nationally advertised and open to tender. To have a long-term future in these conditions, we suggest that colleges will need to change radically their approaches to curriculum and institutional development.

It is our view that the situation shown in Figure 6.3 is new and unique in that the solvency and survival of a college could be decided by the award of a single contract by a small number of large employers. For this we can find no parallel in British post-compulsory education and training. In the public sectors of further and higher education the national funding councils are guaranteeing – in the interests of the stability of institutions – substantial core funding. Typically this core forms 90% of the previous year’s funding and the remainder (‘marginal funding’) is available on the basis of institutions’ bids and/or awards on the basis of measures of quality and efficiency. For the health care colleges and faculties a key factor will be the extent to which RHAs decide to give colleges a degree of protection by intervening if employers’ consortia are inclined, intentionally or otherwise, effectively to close a college by the non-award of a contract (even a 10% loss of funding could be sufficient to render a college insolvent). It may be that this form of protection will be necessary to encourage university corporations to take on the commitment to substantial numbers of staff for whom redundancy costs in the event of reduction and closure would be high. It seems highly unlikely that all RHAs will adopt such a protective policy and none will do so indefinitely.
It has been argued elsewhere that the health care faculties and colleges will, if they are to survive in the conditions created by the imposition of the 'training market', have to adopt a marketing approach to their work (Humphreys, 1993). This will require them to switch from the patient-as-client as their primary curriculum and professional focus. This was acceptable and, indeed, appropriate in the traditional in-house model (Figure 6.1(a)), but in the emerging context they will need to address their thinking to a new client – the service-provider. This shift will be for most colleges a contentious and difficult matter, and it lies at the very heart of the radically new situation they are facing. In the first place the nature and the quality of their provision of education and training will be assessed against the needs of their clients. As these clients, the service providers, influence or take control of education contracts, they are almost certainly going to increase the accuracy and force of their articulation of needs and requirements. It will be in the context of contract negotiation that service priorities, the trainees’ personal and professional development and the needs of the patients can be educationally reconciled.

Thus, programmes of education and training will be designed in the strategic as well as the professional context. They will be purchased, and therefore viewed increasingly, as a key part of a coherent strategy of institutional and staff development, possibly linked to IPR. The role of the nurse tutor will change more profoundly than has been necessary so far in the implementation of Project 2000 courses. From 'guardians of the profession', nurse tutors will become education and training professionals working constructively with their clients, service provider managers and staff. This change of emphasis will lead to conflict as the differences between provision based on needs identified by clients and those identified by professional groups become apparent. At this point the reaction and response of colleges will be critical and the future will be in the hands of the nurse-tutor curriculum development teams. The risk must be that, in the absence of a suitable model of curriculum development (and, of course, for most tutors, of any experience of working for client organizations of the new kind), staff will withdraw into an orthodoxy of commitment to the profession rather than accept the reality of commitment to the client. Commitment to the profession, a manifestation of traditional view of the patient-as-client, might thus be seen as a means of avoiding the necessity of acknowledging the strategic needs and increasingly self-confident demands of service provider organizations. It would also prevent a start being made on the difficult but creative engagement in the task of reconciling issues of quality and relevance as defined by clients, with definitions of these as defined by the National Boards for Nursing, Midwifery and Health Visiting or by the academic standards committees of universities. The design of programmes for education and training cannot be undertaken by the nurse tutor, or course teams, in isolation. Many – if not all – aspects of the college’s organization will influence the adaptation to the new ways of working. In particular institutional structure will need to be changed to 'mirror' client organizations so that information on needs (for design) and evaluation (for responsive teaching and training) can flow in both directions.
With the forthcoming demise of regional health authorities, the future mechanism for education remains unclear. However it is unlikely that the ascendency of the NHS trust or the incorporation of colleges will be reversed. Therefore, the position of colleges/faculties will remain essentially similar to that described above. In these circumstances, institutional development will need to facilitate curriculum and staff development if attempts to respond to the new clients are not to be frustrated by bureaucracy. There is much to be done.

REFERENCES

Editors' introduction

This chapter returns to the paradigmatic issues raised explicitly in Chapters 1 and 2 and evidenced in the case studies and other earlier chapters.

Basic tensions between professional and 'corporate' priorities – particularly with regard to the purpose of education – are considered as sufficiently profound to imply paradigmatic incompatibility. A first attempt to articulate the new paradigm is made and a new model of curriculum development is drawn from development processes implicit in earlier case studies (Chapters 2, 3 and 4).

Within the new paradigm a changed role for nurse education is identified.

INTRODUCTION

Over the last few years, it has been possible to trace ideological shifts in the community of health care educators. A plethora of publications have argued for the rejection of old behaviourist curriculum models. Typically, it is supposed that self-directed learning, critical thinking, action research, reflection on experience (to mention but a few) will, through producing a better practitioner, improve the quality of patient care. In North America, at least, it has been argued that such ideas applied by health care educators have constituted a 'curriculum revolution' (Watson, 1988; Tanner, 1990).
However, as Clare (1993) has recently suggested, it is easier to create a ‘curriculum revolution’ in the literature than it is to change the practices of health care institutions and their professional employees. Nevertheless, not surprisingly, many authors cling to the notion that changes in curriculum are significant in the wider context. For educators of professionals, this must mean changes in that practice for which they are preparing their students. Yet it is by no means clear that education alone can achieve such ends and indeed there has sometimes been evidence to suggest the contrary (e.g. Menzies, 1960). As Clare observed, the literature of nurse education frequently neglects the context of professional practice, as if health care education was an academic exercise divorced from the political environment in which it in fact must operate. As Ellsworth (1989) has shown, the aspirations of education can be defeated by a clinical orthodoxy. It can be argued that such curriculum ‘revolutions’ may be at best insubstantial or at worst irrelevant in the context of professional health care practice.

Professional education then cannot be argued in any real sense to be undergoing revolutionary change, unless there is concurrent and significant change in practice. Furthermore, since we have questioned the possibility of education-led changes in practice, we must enquire as to the circumstances in which revolution can occur at all. The answer to this question constitutes the main theme of this book.

As we have argued in Chapter 1, it is our belief that a revolution in health care education is indeed occurring but that it has been triggered by NHS reorganization. In this argument, the political and ideological climate of health care delivery is not just an important component of, or context for, educational change – it is the origin and driving force of it. In this situation, educators are beginning to act in different ways, consider new values and work from new ideologies – in short, to operate within what can loosely be described as a new paradigm.

PROFESSIONAL AND CORPORATE IMPERATIVES

I have referred above to the belief, commonly held by educators, that they are collectively the determinators of practice. The extent to which this notion is implicit in the literature is remarkable. Educationalists repeatedly describe how their ideas and operations can improve the practice of the profession. The confusion here is perhaps due to a faulty extrapolation from the individual student to the profession as a whole. Since educators do produce skilled individual health care professionals, it is a small step to assume that education determines professional practice. In fact, of course, as professional health care educators are largely selected from the ranks of the health care professions, it is easier to identify a mechanism whereby the profession is the dominant influence on practice. It can be argued therefore that education, through a circular process of initiation and socialization, perpetuates a closed system of values and methods of operation, which is analogous to a Kuhnian paradigm as described in Chapter 1. I will
therefore now consider some of these professional values and contrast them with the business imperatives of the new NHS trusts.

Spurgeon (1993) has identified the NHS as an organization that has been effective in resisting attempts to change it. He describes the NHS as a 'provider-dominated organization' in which professional views of the appropriateness of services have remained paramount and in which aspects of its nature and structure have enabled professional groups to powerfully resist changes (even when not consciously antagonistic to them). The creation of the internal market and with it the setting up of 'purchasers' has been regarded by Ham (1991) as providing a potential counterbalancing force to this provider power.

The idea of a provider-dominated NHS in which professional views are paramount raises various issues for education and training and so will be considered further. How, for example, has such a situation developed? Some insights may be derived from a brief review of the concept of 'professional'. For our present purposes, we are particularly interested in the extent to which professionalism carries implied stances with regard to stasis and change.

Most conventional views on the nature of professionals identify them as involved in some sort of theory-based practice. Additional defining attributes of the professional are more variable but a number of themes recur in the literature. Typically a level of autonomy among individual practitioners is secured by collective regulation and standard setting within the professional group. The application of high-level knowledge by professionals has led in modern times to the idea of professionals striving to update and improve their services by constant reappraisal of practice in the light of increasingly sophisticated theoretical underpinnings. In this context, the emphasis of education has also shifted, with greater consideration now being given to continuing learning throughout the working life (e.g. Houle, 1980). Such a dynamic concept of the professional has influenced pre-registration courses in nursing, for example, which, as we have seen, are commonly explicitly designed to produce autonomous learners, who are both able and inclined to constantly reflect on and review their practice in the light of experience and research.

Professional autonomy, in so far as it exists, would clearly be a creative force for change if based on such dynamic principles as reflective practice and lifelong learning. Indeed it is hardly debatable that, in the Health Care areas, improvements in clinical practice have resulted from research and reflection on practice by continuously learning professionals. Such improvements, however, derive from within the profession and the concept of professional autonomy may have very different consequences for change whose origins lie outside the professional group.

In institutional terms, the dynamic concept of an internally driven profession has its counterpart in the form of self-regulation and standard-setting. The emphasis here is on professionals as responsible or answerable to their professional peers (through the professional body) rather than any extrinsic accountability. In this context, statutory bodies such as ENB or UKCC can play a similar peer
group role. Professionals have therefore long been perceived as being self-organized closed groups (e.g. Flexner, 1915). On the negative side, this collective internal accountability has been interpreted as self-serving and linked with the promotion of social status, mystique and the creation of power bases (Rose, 1974). Illich (1977; 1978) has taken this view further than most.

It is perhaps highly significant in the present context that many analysers of the concept of the professional largely or entirely omit to consider the possibility and implications of their being employed by an organization. Their external responsibility is seen as being direct to the recipient of their services or some concept of society or humanity as a whole.

Where professionals act in independent fee-based practice, the link from individual clients to society as a whole is a simple line relatively unsullied by the complications of employment. On this basis professionals have long been inclined to establish themselves on the moral high ground and to identify 'altruism in motivation' (Flexner, 1915) as one of their characteristics. The existence of an employer, however, can severely compromise this pure concept of professionalism. In circumstances of employment, the context in which professionals operate is subject to other influences and controls. Spurgeon’s (1993) link between an NHS resistant to change and the paramountcy of professional views relates to a situation in which desired changes derive from outside the professional groups. In this situation professional groups, in contrast to their otherwise dynamic approach, appear to represent a status quo. We will now consider the position of NHS provider organizations.

The development of the internal market for health services places newly independent health care provider organizations into a new external environment. Such organizations can only secure their future involvement by achieving contracts from purchasers. Furthermore the market implies an element of competition with other prospective providers. Financially independent organizations such as NHS trusts operate within a finite resource, whose size is essentially determined by the combined values of the contracts they successfully obtain. Such organizations must necessarily employ accounting techniques to ensure a sensible relationship between income and expenditure. Financial accounting is not new to health service organizations. However, whereas some pre-reform providers could get by with merely recording the past and present consumption of resources, there is a greater requirement for NHS trusts to predict expenditure in order to take necessary steps to remain solvent. Cost accounting techniques are therefore increasingly used to analyse the costs of future activity and produce financial forecasts. Such financially independent organizations operating in a competitive market (albeit internal and managed) must make large scale decisions that secure their position through combinations of advantageous activities. Coming to these decisions is the business of strategic planning.

In simple terms, strategic planning derives from monitoring the organization’s external business environment as well as its available resources and competences. For organizations that can articulate broad and long-term commitments, a ‘Mission Statement’ could be a third influence. Strategic planning involves an
analysis of the situation of the organization, and from this various alternatives may emerge. Examples of this process have recently been reported by our colleagues in the University of Greenwich Business School. The managers of one inner London NHS trust, in examining their environment, recognized that as a consequence of government policy, contracts would move from the acute sector into community budgets. Additionally they recognized that an effect of the internal market would be the loss of certain acute contracts to suburban hospitals that could work more cheaply. A major internal feature of the trust was a chronic lack of capital funds that was not alleviated in the move to trust status. In this situation, the trust managers identified two possible alternative strategic responses: to raise revenue by securing new contracts or to cut provision and its consequent expenditure. An analysis of the feasibility of these alternatives led the trust to pursue the second option – a process that will take years and much detailed planning to implement (Baeza, Salt and Tilley, 1993).

In this example, one trust is cutting provision, while another (suburban) trust has gained new business – for them there is the prospect of additional revenue. Whatever the problems or opportunities created by the internal market, the point to recognize is that such organizations are purposive. They are relatively independent and strive to achieve their ends through the deployment of their resources in the best possible way. These desired ends normally include continued involvement in the provision of quality health care.

Most strategic issues arise from the external environment, and the more fluid or volatile that environment, then the more dynamic the organization must be. Strategic planning in the current NHS internal market implies a systematic approach to change designed to ensure the viability of the organization. The sorts of processes described above convey something of the dynamic nature of ‘corporate’ organizations. In the current NHS internal market, these organizations are likely to be making rapid strategic responses based on issues of financial viability through a competitive contracting system. Underlying these systems and processes are values far removed from those typically held by health care professionals.

We have seen that, whereas professionals may be highly innovative in clinical practice, many aspects of professionalism suggest complex and tenacious value systems. These have in the past been established on a (false) assumption of care hardly limited by financial constraints. Add to this the prospect of strategic responses involving (intentionally or otherwise) the erosion of professional power bases or radical skills reprofiling and the potential for conflict within provider organizations can be seen to be great. It is not surprising therefore to find one senior manager complaining of senior professionals ‘holding up’ the process of organizational change (Nettel, 1993).

THE PURPOSE OF EDUCATION AND TRAINING

I have above contrasted professional group characteristics with strategic organizational imperatives. In doing this, I have identified certain value and priority
differences which I believe contribute to the tensions in NHS trusts, and which Spurgeon and others feel impede the development of these organizations. This conflict between the professional and the strategic can be seen further reflected in the process of, and attitudes to, education.

Houle (1980) identified the training of professionals to characteristically include 'deep immersion in a specialized content and the acquisition of difficult skills and a complex value system'. This process he regards as being reinforced by experience (e.g. in a hospital) 'which separates the individual from the general public and permeates her thoughts with a distinctive point of view'. As we have mentioned above, the training of the modern professional nurse potentially at least produces dynamic innovation in terms of clinical practice but additionally s/he receives a 'complex value system and distinctive point of view'. It is in the acquisition of this value system that conflict with employers can arise.

In learning to become a professional nurse, a pre-registration student acquires a range of skills and knowledge appropriate to that role. Additionally the student nurses develop a view of themselves as nurses. In terms of Mead's (1934) social psychological analysis, the students concept of 'self' (i.e. the inner and private view that an individual has of her/himself) changes as a consequence of learning to become a nurse, i.e. the student acquires self-identification with the role. This occurs through a process of socialization.

Working in the 1960s, Simpson (1967) identified the socialization of an adult into an occupational role as a sequential process occurring in three analytically distinct stages. The first phase involves a shift from the layperson's view of nurse to the profession's view. Simpson's work showed that in the 1960s the school of nursing at which she studied accomplished this transformation by emphasizing the mastery of technical skills and knowledge (rather than the nurturing of patients which has dominated the students' lay concept of nurse). The second stage of socialization involved the student coming to share other hospital personnel's orientation towards the work situation. Whereas initially the student nurses had considered the patients as 'significant others' in the work situation, the commencement of clinical training had the effect of shifting the student orientation into line with other hospital personnel with whom they developed relationships and attachments. Finally the third stage involved the adoption by the student of behaviour and values presented by the occupational group.

Simpson's work revealed that the college and the clinical area contributed in consistent ways to the development of the professional. For instance, the first-stage shift from the layperson's to the professional's view of nursing was developed by the fact that neither college work or clinical work emphasized nurturing (the college emphasized theory while the clinical work emphasized techniques). Whereas Simpson's work may not represent the present-day practices of nurse education, it does illustrate how the education of a professional nurse involves a process of socialization into current values and practices, and how college tutors and placement staff can effectively collaborate in this process. It is inevitable in such circumstances that the training of nurses tends to generate a new cohort
broadly showing the values of the established professionals. In the context of in-house training of nurses (in the sense identified in Chapter 6 where DHA colleges trained for DHA hospitals) whose role is basically stable, such processes of socialization present few real issues and are relatively unproblematic.

Consider, however, the position of a rapidly changing role for nurses in which not only skills and knowledge but also certain professional values are in a process of change. By what means, for example, can the idea of the delivery of health care in the context of a finite resource be taught to student nurses, who must learn skills and values that their predecessors and indeed teachers have not needed to employ? The implications of such changes for nurse education are significant.

It is the employer’s perception of education and training that I wish now to consider. Management literature on education and training, whether prior to employment (pre-service) or during employment (in-service) tends to explicitly or implicitly link it with consequent benefit (via the employee) to organizational objectives. Such matters, however, are not considered only in relation to what might be called technical competence. Those involved in the recruitment and selection of staff, for example, are commonly advised to consider how new members of staff would fit into the cultural and social structure of the organization (e.g. Mullins, 1993). Such comments are of particular interest in the area of pre-registration nurse education since organizational culture as commonly defined includes, among other things, values, beliefs and attitudes (McClean and Marshall, 1993) that permeate the organization. As health service provider organizations move into an internal market, certain values are likely to shift and with them over time aspects of organizational culture. Mullins also advises investigation into the potential of prospective appointees, including their flexibility and adaptability to possible new methods, procedures or working conditions. Such ideas in management textbooks are by no means novel; furthermore it is reasonable to suppose that service provider managers, when recruiting health care professionals, look for a composite of skills, values and flexibilities consistent with their perception of the development of the organization.

In-service training of staff in organizational terms is generally seen as an integral part of quality management. Its purpose is considered to be to improve knowledge and skills and 'improve attitudes' (Mullins, 1993). Although recognized as being given low priority in many organizations, it is seen at best as linked to the strategic priorities of the organization (Fill and Mullins, 1990). Thus it is considered a key support system for change and an investment in the long-term survival of the organization. Furthermore, there is evidence that these general ideas are informing the responses of managers. A senior health service manager has, for example recently reported introducing training initiatives related to strategy, market, culture and overall organizational changes, through which every member of staff is clear about her/his role (Nettel, 1993).

In short, employers identify instrumental purposes for education and training. Their priorities relate to quality and the strategic development of their organization...
and it is generally recognized that education and training is important in relation to values and attitudes, as well as knowledge and skills.

In comparing professional groups and employing organizations in terms of their attitudes to education and training, it is interesting to note that both groups (at least in the literature) attach great importance to education and training but with very different emphasis. Whereas organizational managers identify education and training as a major influence on the success of organizations, professional groups see it as a means of entry into the profession or as a means of upgrading and modernizing knowledge and clinical skills. These different emphases are of course not mutually exclusive. However they do represent ideological differences which in conventional curriculum theory implies different approaches to education and training.

CURRICULUM IDEOLOGIES

Ideology has been defined as a set of related ideas and values held by individuals and groups (OU, 1976). Scrimshaw (1983) has emphasized the role of ideologies as a basis for the determination of the actions of those who hold them. Even in the compulsory sectors of education, school curricula are specified in line with the prevailing ideology of groups with power. This is an important point, since literature on curriculum ideologies is sometimes taken to imply that the prevailing ideology is established by teachers, who apply their beliefs in the design of curriculum. Even in health care education, where teachers have considerable direct control over curriculum design, the prevailing educational ideology is established increasingly by groups external to the teaching community, exerting power. Pendleton (1991) has expressed the view that 'reconstructionist' ideology (Chapter 2) is most relevant to nurse education since nurses, due to their position and experience can be at the forefront of those who work for social justice. This view exemplifies the professional as opposed to corporate priorities identified earlier. Although most educators probably have beliefs and values which are or could constitute an ideology, the beliefs of individuals or even groups of individuals do not necessarily represent a prevailing (i.e. dominant) ideology. In fact, just as in school education, the prevailing educational ideology is the one held by groups with sufficient collective power to exert the predominant influence. In the case of nurse education, analyses in earlier chapters of this book reveal a market for education in which, increasingly, purchasing decisions will be under the influence of health care provider organizations.

In the context of education the employer's ideology, as we have seen, is generally instrumental in nature. Employers must necessarily concern themselves primarily with the impact of education and training on their ability to deliver patient care and to develop as organizations.

In this context, the ideologies that may be held by nurse educators, although of interest are of real significance only in terms of the extent to which they cor-
respond to the prevailing ideology. Where there is a profound mismatch between
the prevailing ideology and the ideology of a nurse educator, problems can
develop. These I will discuss later. Similarly curriculum theorists inclined to
compose models and recommend approaches to curriculum development
without first identifying the ideological environment in which the curricula must
operate are also neglecting important realities. For these reasons I will restrict
myself to types of response for an educational climate in which instrumental
ideologies are politically ascendent.

Scrimshaw (1983) has made distinctions between what he calls traditional and
adaptive instrumentalism. Although his analysis relates to schooling and the
needs of society in terms of a skilled workforce, it is also of some interest in the
present context. Traditional instrumentalism assumes a relatively stable situation
and implies an emphasis on defined vocational skills. Conversely, adaptive
instrumentalism identifies complex and changing situations in which specific
skills will become obsolete. The emphasis therefore shifts to accommodate those
skills which are required across a range of situations (defined as ‘transferable’
skills) or those which contribute to the individual’s ability to actively adjust and
develop her/his skills to make them applicable in the new situation (defined by
Annett, 1989 as ‘transfer skills’).

Adaptive instrumentalism is taken by Scrimshaw to imply classroom activi­
ties such as group work, guided discussion, problem solving etc. However, al­
though adaptive instrumentalism may often be associated with such approaches,
there is no logical necessity for this to follow. Wellington’s 1989 conception of
‘deferred instrumentalism’ (Wellington, 1993) is instructive in this context. This
idea derives from the observation that many employers preferentially recruit on
the basis of purely ‘academic’ qualifications. In so far as they see these as indi­
cating general transferable and transfer skills, the ideological background may
be described as adaptive instrumentalist. However, such academic qualifications
may not have been achieved on the basis of group work, guided discussion and
problem solving approaches.

In order to make some progress in this area, I would like, for the purposes of
debate, to describe a form of instrumentalism derived explicitly from our earlier
analysis of the situation in health care education.

As NHS trusts are formed, the education of nurses increasingly prepares or
enhances the ability of a professional to operate in a ‘corporate’ setting. This, as
we have discussed, carries implications for education and training. Notably edu­
cation and training is increasingly seen as explicitly linked to organizational
needs including service quality and organizational development. Since trusts are
independent financial organizations, which must compete for business, implied
values include working within financial constraints. This leads to values relating
to cost-effectiveness, efficiency, etc., as well as the ethical values traditionally
associated with health care services. Since education and training is seen as
linked to organizational development, it should be a force for change not stasis.
For example, in the case of strategic planning including skills reprofiling of
professional groups or delivery by practitioners of health care in a finite bud­
getary setting, education and training would be contributing to these changes. In
organizational terms, it would be incoherent to purchase education and training
that did not assist with these things.

An ideological stance, which is instrumental and identifies these explicit links
between education and the quality, efficiency and development of an independ­
ent organization, I will identify as 'corporate instrumentalism'. Corporate
instrumentalism has some similarities to both traditional and adaptive instru­
mentalism. On the one hand, it implies certain specific features of education and
training, including understanding of resourcing and costs but, although these
may be considered as specific vocational skills, they are largely transferable.
However it is distinct in its implied focus on the needs of individual
organizations.

Whereas 'corporate instrumentalism' is an ideological position informing em­
ployers' views on education and training, it is rarely significant in vocational ed­
ucation. This is because most vocational and professional education is not
directly linked into the specific needs of individual corporate organizations;
rather its purpose is to provide a national workforce from which employers
select. In this context, employers merely provide advice (through advisory com­
mittees and so forth), they are not involved in contracting of education. Chapter
6, however, has identified health care education as unique in the extent to which
local employers are actually involved in contracting. Therefore the connection
between the specific (and strategic) needs of the employer can be seen as a feasible
and legitimate influence on education. In these circumstances, corporate in­
strumentalism becomes the dominating ideology and must be the ideological
basis for effective models of curriculum development. (See Silver and Brennan,
1988 for a detailed analysis of the spectrum of links between education and
workforce supply.)

CURRICULUM AS PRODUCT

Earlier parts of this book have analysed and described what is essentially a
market for education. In this market, education provider organizations offer ser­
vices to purchasers. Chapters 6 and 7 have shown some of these purchasers as
increasingly inclined to devolve purchasing decisions to consortia of NHS trusts.
In any event trusts' influence over education is increasing. In this new environ­
ment, education providers tend to lie outside the NHS (as corporate universities)
and therefore we have the organizational financial and legal distinction between
purchaser and provider, which constitutes the main characteristic of the market.
For education providers, such a radically changed environment is demanding
new approaches. In particular, the onus is on the provider to ensure effective re­
lationships with the purchaser. This interface between purchaser and provider
falls within the domain of the business discipline called 'marketing' and it is
from the established theories of marketing that we can find useful practices for the future of health care education.

The purpose of marketing is to enable or facilitate voluntary and mutually advantageous exchange relationships. In our case, 'exchange' refers to the purchasing of educational services, through which colleges achieve revenue, and the output of colleges (skilled practitioners), through which purchasers achieve workforce supply.

The word 'marketing' is wrongly sometimes associated by some with illegitimate exchanges, in which coercion or deceit bring about normally one-off exchanges unsatisfactory to the purchaser. In fact, such techniques have never been a part of marketing proper and today they represent the antithesis of the modern marketing concept, which identifies purchaser satisfaction as of fundamental importance. A second misconception is the widely held belief that marketing equates to advertising or promotional activity. In fact, this represents a milder version of the misconception above, in that both involve a sales orientation in which otherwise insufficient demand is boosted by increasing sales-related activity. There are, however, circumstances in which advertising can indeed create a new market or lead to increased demand. But in health care education this possibility is closed off to an unusual degree since (as Stanwick has discussed in Chapter 7) the purchasing of pre-registration education is explicitly (although not always accurately) matched to employer demand based on workforce analysis.

Whereas educational organizations are generally not inclined to adopt coercion or deceit, they are, in our experience, sometimes prone to adopt a sales orientation rather than address the nature of their services as marketing proper would compel them to do (Humphreys, 1993). Although promotional activity is a legitimate part of marketing, its success will depend on the idea, at the very heart of marketing, that colleges should provide services that purchasers want to buy, rather than trying to persuade them to buy what they choose to provide.

Clearly marketing fits well with instrumental ideologies. Consider an organization and its purchasers. Both have reasons for their interaction. The selling organization achieves its goals and the customers will remain only as long as the product or services satisfies their requirements. The system depends on and therefore encourages mutual satisfaction. This is the conception of marketing that I will apply. In so far as it is overtly instrumental, it is clear and unambiguous and if, at worst, it leads organizations sometimes to confuse self-interest and altruism, this probably happens no more often in purchaser-oriented corporate colleges than it does in professional bodies.

The modern idea of marketing emerged in the 1950s. Recognition of the importance of marketing to education institutions has grown during the 1980s as they have, like NHS trusts, gained autonomy and financial independence (see Chapter 6). Despite an increased profile for marketing in post-compulsory education and training (see for example Davies and Scribbens, 1985; Theodossin, 1989) there is still a great inclination to apply it in limited ways which, while
they may improve consumer satisfaction, they may not profoundly affect the service. Such valuable but limited responses include attention to student facilities and corporate image.

The real 'product' of an education provider, however, is learning as experienced by students, i.e. the curriculum in operation. For the student this will contribute significantly to her/his competence, employability and/or professional development. For the employer it can contribute, as we have seen, to the quality of service and strategic development. The most important effect of marketing therefore is the effect it has on the curriculum.

Even in commercial corporate organizations, marketing is by no means a universal philosophy. Doyle (1987) for example found that only 50% of firms he studied developed a genuine consumer orientation. For education organizations, a marketing orientation is not easy to achieve. In particular, it can challenge many conventions (and ideologies). There is, for example, a widely held inclination amongst nurse educators to focus on internal priorities when developing and operating their services. Such internal priorities may involve the ascendancy in curriculum development of epistemological commitments over client needs. For example, a lecturer insisting on a lot of biology in a pre-service curriculum could be asserting this on the basis of genuine customer orientation. Alternatively, he might be doing it because he was a biologist or because he took a liberal, humanist, ideological stance in which science was considered 'important'.

This example illustrates the challenges that marketing creates. Unwillingness to respond to client needs can also be revealed by the use of curriculum dogma (e.g. misused concepts of coherence and progression to put unnecessary limits on flexibility) or a reluctance to tackle operational issues that appears to favour the status quo (e.g. 'it can't be timetabled'). Common to all the curriculum case studies (Chapters 3, 4 and 5) is a disinclination to observe such conventions.

The need to improve the match between employer need and vocational curricula is not new. While the non-advanced further education sector has been encouraged for some time to become more responsive to employment needs (see for example, Cribb et al., 1989), higher education is, particularly through the development and operation of credit accumulation and transfer schemes, recognizing a changed role in the education of professionals (see for example, THES, 1992).

In the general area of professional and vocational training, various authors have given consideration to the significance, in marketing terms, of students and employers. Gray (1989), for example, distinguishes between the two by referring to students as 'customers' and employers as 'clients'. Whether or not students are employees, professional education and training must prepare them to fulfil competently a professional role in an employing organization. Regardless of vocational area, professional courses will at best resolve many apparent conflicts that arise between student and employer need.

It is also important for colleges to formulate a concept of quality which accommodates the clients on which they depend. A key element in any client-
sensitive concept of quality will be the match between needs and provision. This apparently simple relationship represents the heart of the marketing idea. Although many colleges would claim a good match, it is very often less apparent to the outside observer than they might think. Current practice appears often to relate provision to needs as perceived in the minds of curriculum developers rather than actual needs. However even national boards (albeit inconsistently) are starting to make the link between quality and the ‘corporate objectives’ of service providers (ENB, 1990).

While NHS trusts increasingly express concern over the relevance and costs of conventional health care education, many nurse educators, in the absence of any real alternative, practise curriculum development in line with anachronistic but still prevalent methods. While health care itself has shifted to a client-centred stance, health care education struggles with essentially conventional systems of values, beliefs and practices. A nurse tutor, for example, resorting to standard texts on curriculum and curriculum development will find little or no guidance on marketing in relation to curriculum design and, despite some theoretical consideration of instrumentalist curriculum models, no mention of clients (in the sense of NHS trusts).

Yet the situation in health care education now demands a synthesis capable of resolving marketing and the more valuable elements of conventional curriculum theory (Humphreys, 1993). In attempting to begin such a synthesis, I will now consider the marketing equivalent of the practice of curriculum development.

In marketing terms the concept of the ‘product’ refers to more than simply the basic nature of what is being sold. To the purchaser the ‘product’ represents a combination of perceived benefits that will meet her/his needs. In designing a product, care is taken to ensure that the full range of the product’s attributes are collectively sufficient to interest the purchaser. In educational terms these attributes include the availability of the course (time, location, frequency, etc.) and the price. In marketing terms, the range of attributes associated with a product is referred to as the ‘marketing mix’. On the basis of knowledge of the market, including competitor positions, the marketing mix is adjusted in such a way as to best match the product’s attributes with identified purchaser needs.

From the case studies described in Chapters 3, 4 and 5, it is possible to abstract certain generic features of the ‘curriculum as product’ which together constitute a more or less desirable collection of attributes for the purchaser.

Coverage

From the purchaser’s point of view, the primary purpose of a course of professional education generally relates to the professional abilities acquired through participation. It is presumed that after participation the learner can do something new or do something better. What it is that s/he is supposed to learn or improve constitutes coverage. The justification for that coverage must derive from the actual or anticipated clinical and other demands in the workplace. For example,
a new nurse expected to give intravenous injections immediately on appointment should be equipped with the appropriate knowledge and skills during the course. Although aspects of coverage are established for pre-registration courses by statutory bodies, there remains considerable opportunity for local focus. However it is likely that coverage will remain largely within the control of the educator, rather than the student. In post-registration learning, the professional her/himself may be in a position to partly or wholly determine coverage. Some award-bearing programmes recognize this by leaving coverage entirely open for negotiation.

Coverage may be expressed in various technical formats. Increasingly ‘standards’, competence statements or learning outcomes are replacing conventional content-laden syllabuses. In any event, a marketing orientation would imply that coverage should be expressed in sufficiently non-technical specification to be accessible to the purchaser.

A recent empirical investigation into trust chief executive views on education (Humphreys, Stanwick and Wood, 1993) identified the match between coverage and future (as opposed to existing) needs to be an important aspect of the quality of education, a point which illustrates the strategic priorities of trust managers in times of change.

Process

By this is meant the processes by which learning is facilitated. Experienced educators often link the process of learning to the desired outcome. This is considered particularly important for the development of professionals as relatively autonomous lifelong learners. In fact, distinct ideologies revolve round the relative importance of content and process. At best, however, in the day-to-day functions of the professional teacher it is not considered an ideological debate. For some hard-pressed clinical practitioners, there may be times where a simple transfer of distilled information may be the most effective approach a teacher can adopt.

Systems

For want of a better word, ‘system’ is used to describe the range of curriculum structures and facilities from which a curriculum developer must select. These range from an orthodox simple linear sequence through spiral and modular curricula to credit systems with the potential for enormous variability in the way two consumers achieve comparable ends (or indeed different negotiated ends).

Patterns of contact

Contact here refers to face-to-face interaction between student and teacher. In orthodox timetabled programmes a key issue may be the extent to which the timing
and pattern of contact provides for easy access. This can be important in both pre- and post-registration education, for some students because of increasingly non-traditional career paths (ENB, 1990) and for others because of pattern of work demand (such as night shifts). Additionally the overall design times of a course (in terms of class contact rather than learning time) and the time interval (or intervals) over which it can be done, are important aspects of curriculum as product.

Learning resources

Appropriate provision of learning resources may take a range of forms from study space and library resources through computer hardware and software to distance learning materials and, of course, access to clinical areas.

Location

Although it is conventional to operate on college premises, alternative approaches are increasingly being taken. Chapter 4, for example, illustrates how a degree level programme of professional development can be achieved through a combination of distance learning and shorter courses based in clinical settings.

Assessment

Conventional curriculum ideologies link approaches to assessment with aspects of process. However even some sacred cows of assessment are being re-examined. The move to competences within NVQ developments has led to the complete detachment of summative assessment from the learning process, with the result that ‘assessment on demand’ is now considered as a reasonable and normal service to offer to consumers. A more robust link is enshrined in the curriculum concept of assessment ‘validity’ which links assessment to the nature of the acquired learning (i.e. coverage). Thus, it is considered invalid to assess clinical skills only through written examinations, since written examinations can only test certain components of clinical skills.

Price

Although pricing must ensure that income covers costs, since different approaches carry different costs, there is considerable scope for manipulating other features (e.g. patterns of contact) of curriculum design in order to allow the best combination of attributes.

It is essential to appreciate that none of these features of the curriculum can be seen in isolation. For example, location can interact with learning resources and pattern of contact and coverage can imply process. In fact all eight features can interact in line with the constraints and priorities of the curriculum developer. In
a marketing context, the manipulation of these various attributes to produce the best possible combination for the client, represents a new and challenging aspect of curriculum development.

This complex concept of 'product' results in product development procedures that typically include location, price, etc. as an integral rather than peripheral part of product development. However, this is in stark contrast to conventional models of curriculum development. As higher education has become a largely corporate endeavour, resource issues are seen increasingly as a necessary element of the curriculum development process. However this idea has not yet penetrated the literature. Even quite recent textbooks on curriculum and curriculum development fail to make this link (e.g. Pendleton and Myles, 1991; Allen and Jolley, 1987) with the result that there is little appropriate guidance now available for curriculum developers.

A NEW MODEL FOR CURRICULUM DEVELOPMENT

The model of curriculum development identified here has, over the last five years, become implicit in the work of the School of Post Compulsory Education and Training (PCET) at the University of Greenwich. The School is exclusively involved in professional level education and training and operates in a range of market situations. Common to all our work is a need to persuade employers to either use our services directly or to employ our trained output from pre-service programmes. From an initial involvement in the training of further education lecturers and nurse-tutors, we branched out into nursing, midwifery, physiotherapy and social work. Many of these developments involved collaborations with other organizations and, through these collaborations (illustrated by case studies in Chapters 3 and 4) we learnt new ideas and refined our own developmental expertise. Whereas we have been at the forefront of various national developments, we would not claim originality for many of the ideas we have applied. However, in so far as we have had successes, it has been on the basis of developmental approaches which have emerged from the work of PCET staff teams over the last few years (combined with basic operational skills and good practice).

In making our curriculum development model explicit I have had to include all the major elements which make it balanced and complete. In different developments, different parts of the model need emphasis and some parts can be neglected. Where development is collaborative, the sequence and processes must accommodate the partner organization. In any event, the model presupposes an inclination to succeed through the satisfaction of client needs; a constant search for innovation and improvement; and a reluctance to be constrained by conventional curriculum dogma. The model applies to the development of both new and existing curricula.

For convenience of explanation, the model can be considered to consist of three stages: planning, development and validation. Figure 9.1 shows the complete model.
Figure 9.1 A model for curriculum development. The largest and central square in the diagram shows the ‘curriculum as product’ as described in the text. Initial planning is followed by a development stage in which work on resourcing (above) and regulatory issues (below) are seen as distinct from, although in practice integrated with, more orthodox aspects of curriculum development (central strand). A subsequent ‘validation’ stage involves checking the curriculum design to ensure both positive consumer response and satisfactory cost-price relations. At this point also conventional validation and/or accreditation processes are progressed while a promotional campaign is designed. During the operational stage, evaluation processes monitor fitness for purpose by focusing on client needs as well as the more conventional aspects of educational evaluation. Evaluation feeds into planning and thus a cycle is established.
Planning stage

Planning begins with the identification of an unsatisfied client need. For any organization wishing to diversify, this may have resulted from a systematic search for opportunities. Alternatively, for an existing programme information may derive from employers, students or perhaps increasingly successful competitors.

An initially perceived unsatisfied need generally requires investigating (market information) to ensure firstly, that it is sufficiently widespread to make a response worthwhile, and secondly, that the exact nature of the need is understood. The proposed response in broad terms can be referred to as the ‘initial concept’. Although such a concept could be developed de novo, it is best, where possible, to apply existing institutional strengths, providing these do not distort the concept beyond the point where it will meet the perceived need.

As an example of this process, we would cite our own collaboration with Macmillan, publishers of Nursing Times. The advent of P2000 etc. marked the obsolescence of the enrolled nurse. This position is unsatisfactory for enrolled nurses, many of whom saw conversion to registered nurse as a solution. Market information revealed the level of dissatisfaction to be very great; in some districts it was estimated that, with the current availability of enrolled nurse conversion courses, it would take 10 years to convert the enrolled nurses who wished to do so. Macmillan linked this unsatisfied need to their strength as publishers and set up the Nursing Times Open Learning Scheme (NTOL) which was accredited by all four UK National Boards in 1991. In 1993, NTOL reached agreement with the University of Greenwich School of Post Compulsory Education and Training (PCET) to recognize the NTOL programme as credit towards a higher education qualification. At that time, PCET had developed a strength in the application of credit systems to professional training. PCET aware of a related need for existing registered nurses also to achieve higher education qualifications proposed a linked credit-based development for both markets. It is now possible for both enrolled and registered nurses to work to a University of Greenwich Diploma of Higher Education through Nursing Times Open Learning. Currently over 2000 students are enrolled.

In this case, the concept applied strengths in publishing and in credit schemes to two related and unsatisfied needs. The resulting programmes operate on the basis of distance learning materials published weekly in Nursing Times, and support available through approved centres around the UK.

Development stage

The developmental stage consists of three elements, shown in Figure 9.1 as running in parallel but in fact to a large degree integrated. These relate to resourcing and regulatory factors, as well as ‘design’ features relating to coverage and systems. Each will be considered in turn.
In order to properly establish the nature of resourcing issues that must be considered in the model, it is first necessary to briefly address some background information on the past and future practices of college finance.

Colleges which formed part of district health authorities (Chapter 7) are subject to that organization's financial accounting systems. These systems were designed to keep accurate records of their financial affairs, including expenditure and income. Typically, expenditure on the college would constitute a relatively small part of a large overall DHA annual spend. Furthermore, instead of college expenditure being drawn from special college budgets, it has been the practice with many colleges for expenditure to be drawn from the general budgets of the parent organization. So, for example, salaries of college staff would be drawn from staffing budgets that covered other district employees, while building maintenance, cleaning services, etc. would likewise be covered by district budgets.

In these circumstances a college is not seen as a financially separate part of the DHA and, because of this, there is no comprehensive overall annual figure of total college expenditure. Indeed, even when such a figure is desired, it can be very difficult to get at since most financial information on the college is 'lost' among the millions of pieces of data in the overall DHA financial accounting system.

A college in this position is not of course free from various financial constraints. In particular limits can be put on more easily distinguished college expenditure such as on staffing. Typically a college would have a staff 'establishment' based on some estimate of how many staff would be needed to sustain the education and training function. Student–staff ratio (SSR) could provide the basis for calculating establishments but in fact SSR used in this way is problematic, not least because of numerous variations in the way it can be calculated. Often SSR had provided a rough basis, in addition to which negotiations between a college and its parent organization over particular cases for extra staffing might be argued and sometimes accommodated.

We could refer to this method of resourcing as 'education-led'. Behind it are fairly orthodox educational assumptions about class sizes and methods of teaching and learning. In some colleges it has been the practice to design a curriculum and then calculate the resource needed to run it. If the available resource falls short, then a case is made for more. It has also been common practice in colleges of nursing to argue for extra resourcing for the development of new programmes. This also is a logical request in a system that derives an establishment primarily from estimating what is needed to operate (rather than develop) courses.

In summary, the past (and for some, present) situation is ignorance about the total expenditure of a college and 'education-led' college resourcing systems. We must now compare this with the financial and budgetary system necessary for colleges which are, or form part of independent financial organizations (such as universities).
A limitation of financial accounting is that it is concerned with the past and the present. Expenditure is only known about after it has occurred (or money has been committed). This alone is insufficient for many financially independent organizations which need to anticipate future financial positions. The cost of a service such as a course includes all the money spent on providing it. It is made up of ‘direct costs’ such as labour and materials together with its apportioned share of overheads such as building maintenance and rent. These latter ‘indirect costs’ also include a portion of staffing costs for the personnel, finance and other departments not directly involved in the service delivered. In educational organizations it is not uncommon for the indirect costs of a service to be more than the direct costs.

In a market situation the full cost of a service must normally be known in order to establish a price. As we have seen the information about the costs of whole colleges is often hard to achieve and the costs of individual courses are even more remote. In the reorganized NHS, hospital trusts are having very similar problems and it is partly because of this that service contracting is currently negotiated coarsely for large numbers of ‘completed consultant incidents’. However contract prices are achieved, they must nevertheless cover costs. If they do not, then the financial viability of the organization may be at risk and drastic measures may need to be taken.

In this context, courses must be designed to operate within a specified resource and curriculum development must include resourcing as an integral part of course design. Since the income to cover costs comes ultimately from the purchaser, the process of curriculum development might be described as ‘market-led’.

An organization with adequate cost accounting systems may, through its managers, simply constrain curriculum development groups to design services that can operate within anticipated income, i.e. the relationship between anticipated income and expenditure is clear, explicit and expressed in terms of money. Frequently, however, educational organizations do not yet have sufficiently sophisticated costing systems with the consequence that they identify resources available to courses in currencies other than money. Commonly for example they may determine the staffing resource through an SSR calculation. In this market-led situation, however, SSR is used as the basis of a formula to determine available resource.

The distinction between the uses of SSR in ‘education-led’ and ‘market-led’ contexts is subtle but profound. ENB, for example, specify an SSR as a means of ensuring what they consider to be a satisfactory staff level. There is a notional relationship between SSR and class sizes, etc. which is assumed to relate in some way to quality – i.e. SSR is being used to ensure quality. There is no implied knowledge of actual income–expenditure relationships.

On the other hand, in a market-led situation, SSR is used as a means of manipulating the income–expenditure relationship in such a way as to ensure that income covers costs. In these circumstances, a course team is given an SSR
from which, combined with target recruitment, it can calculate the total hourage available for the course. For example, if a college knew that, in order to make ends meet, it needed courses in a particular department to run on an SSR of 20:1 then, for each 20 full-time students, one member of staff would be available. If, say, one member of staff could teach 15 hours per week, then 20 students would generate 15 class contact hours and the design team would have to work within this resource (this example is simplified).

To summarize, in an education-led resourcing system, SSR is established on the basis of some idea of quality, and expenditure is a consequence of this. Conversely, in a market-led resourcing system, SSR is established on the basis of anticipated income and quality is derived from the skills of the curriculum developer who must design the course to operate within the anticipated available resource.

Increasingly higher education organizations are moving away from SSR as part of a 'market-led' resource deployment formula, and instead introducing so-called 'cost centres' in which income and expenditure are even more explicitly and directly linked. Here the full costs (direct and indirect) of a course must normally be met by income. In a contracting system, the price is set to at least cover costs. In designing curricula, therefore, a team must consider the collective attractiveness to purchasers of various patterns of attributes: inclusive of price and programme design. There is unlikely to be a long-term benefit in sacrificing basic sufficient quality for reduced prices. However those curriculum development teams who can imaginatively design cost-effective programmes will be highly valuable to their organizations. Such programmes may be highly innovative in design, a possibility we will discuss further below.

**Regulations**

Because there is nothing new about the need for programmes to comply with various regulations, this section will be kept brief. Such regulations are established by internal and external groups with power, who for various reasons must constrain curriculum development teams or sometimes encourage them to develop in particular directions. Internal regulations in universities are often specified in order to keep a broad consistency in the various programmes offered across the whole organization. Typically they are established by 'academic standards' committees and ensured via the university procedures for course validation. In the new universities, academic standards committees serve a purpose analogous to the former (external) role of the Council for National Academic Awards. They are positioned outside the managerial structure of the university and remain independent of cost centres.

External regulatory organizations include statutory bodies such as the national boards and NCVQ, professional bodies, such as the Chartered Society of Physiotherapists, and curriculum agencies such as BTEC, City and Guilds, etc. Although, in many ways constraining and to some extent inevitably lagging behind
the forefront of curriculum design, some are inclined to encourage innovation and, in doing this, can facilitate development in those education providers who need a push. Examples of such facilitation is provided in Chapter 3 and 4 of this book.

In any event, regulations established by such organizations constitute an important part of the environment in which education providers must operate.

Design

As we have seen, regulations, although constraining, generally leave considerable discretion to the curriculum developer. Resource issues, on the other hand, can (depending on the particular college) interact dynamically with other aspects of the product. For instance a lower cost curriculum may require less ‘teaching’ through class contact with greater emphasis on alternative learning situations. This is by no means a straightforward or easily predictable relationship. The development of learning resources for distance learning, for example, carries considerable development and production costs. Whether or not distance learning approaches carry more or less cost is dependent on parameters including target and actual recruitment, lifespan of the curriculum and specific patterns and extent of tutorial time, classroom use, access to library, etc. Nevertheless, in the increasing number of colleges with adequate cost accounting systems, it is feasible for costs and therefore prices to be one of the variables that developers can manipulate during the curriculum design process. Without this flexible facility cost will be a more static factor but, since it must be limited within anticipated income (directly or through SSR minima), it remains an integral part of curriculum development.

Whatever the cost and regulation circumstances, curriculum developers must make design decisions. In this model the curriculum developer can use her/his professional judgement to assemble the best design elements for the particular situation. From our earlier discussion, we know that design must include: coverage, processes and systems. However, in reality, the three often tend to be highly interdependent. Competences or learning goals, for example, signify both content and learning process. Similarly, APEL and CATS systems can be incompatible with close and tightly sequenced curricula. Nevertheless, there is considerable scope for designing the curriculum to best meet the client needs. Chapter 5 described a curriculum development process that was designed explicitly to accommodate the needs of both the employing organizations and in-service students. Among the various attributes assembled were a combination of competences and learning goals, as this was considered the strongest response to the situation identified in the Planning Stage.

The model (Figure 9.1) identifies three distinct functional elements in the design process: coverage specification; applied human sciences and systems innovations. These will be considered in turn.

In this model, coverage is derived from client need. Whereas this may seem an obvious statement, we have seen that there is a tendency instead amongst
A NEW MODEL FOR CURRICULUM DEVELOPMENT

curriculum developers to focus on internal priorities derived from non-instrumental ideological stances. Curriculum developers should be careful not to overvalue their own personal views as to what should be included. This can lead to blatantly self-serving priorities (such as the biologist mentioned earlier who emphasizes the importance of biology and argues for more, rather than less, regardless of whether it is appropriate). Even more genuine ideologically derived arguments can take the focus off client need. These may include purely epistemological justifications for ‘coherence’ or conventional humanist-derived arguments for studies with only peripheral relevance. Such approaches may be appropriate for school education but do little to enhance professional education purchased by employers. Furthermore, in the education of health care professions, the inclusion of secure knowledge bases, ethics, transferable skills, etc. may often legitimately derive from a client-led approach. Where these things are important, this curriculum model will deliver them.

Coverage is sometimes taken to imply fixed sequence. This sort of approach can derive from the behaviourist tradition but also from the otherwise incompatible area of cognitive psychology. In the latter case an analysis of the conceptual structure of a subject may help to identify prerequisite relationships which suggest necessary learning sequences (e.g. Humphreys, 1987) for biology. The idea of necessary sequence, however, can be taken beyond that which conceptual analysis can justify. Where this happens, the unnecessary reduction in curriculum flexibility can run counter to client interests.

Knowles’s work on the adult learner and Schon’s on the autonomous professional (both discussed in the earlier chapters) have led to more flexible approaches to curriculum design in which the needs of individual learners can be accommodated. In the School of PCET, we have been introducing ‘real time’ flexibility into curricula, such that professionals in both initial and post-experience training can select units of learning when the work demand requires particular knowledge and skills. In this way, the demand on professionals is matched in terms of both the coverage and timing of particular learning programmes (add to this flexibility of location and the true significance of this approach begins to emerge).

Where prerequisite relationships between concepts/skills, etc. are genuine, then a skilled professional educator will recognize them. Beyond this, however, flexible approaches to content sequence may be beneficial. The best balance may depend on the stage of the individual in her/his training. Certainly preregistration programmes are likely to be more structured; even here, however, there is much more opportunity than is sometimes appreciated.

The use of conceptual analysis to determine real prerequisite relationships shows how human sciences (in this case psychology) can be applied by the expert educator to enhance the design of curricula. Mike Kelly, a colleague at the University of Greenwich, has recently described an approach to curriculum development, in which explicit instrumental objectives were accommodated into curriculum design by the application of models of behaviour. Kelly and
Maloney (1992) were involved in the development of a health promotion course for nurses. Underlying the course was a concern that stress-related health effects on nurses were impinging on morale, turnover, absenteeism, general patient care and the delivery of services. In designing a programme to improve this situation Kelly and Maloney applied a model of stress-coping developed by Lazarus (1980). Lazarus identified coping as consisting of threat recognition followed by a decision about appropriate action. The former is information-based and the latter skill-based. In curriculum terms the implication is that information alone is inadequate. If the objective is a reduction in smoking rates, then in addition to information about the dangers of smoking nurses would also need to develop the necessary skills to give up (Kelly, 1990).

The final element in the curriculum design process relates to systems innovations. By this is meant structural configurations (such as spiral curricula, curriculum stages or parts, modularity, etc.) and system facilities such as flexibility, negotiation, APEL and APL.

![Diagram](https://via.placeholder.com/150)

**Figure 9.2** Functional links between employer, college and student, with two examples of curriculum systems innovations at each interface. Through pre-service training the college produces a workforce supply for the employer. Recruitment from this pool is followed by ongoing staff development often through in-service training by the college. For the individual this contributes to her/his development as a professional. These functional links can be facilitated by curriculum systems innovations (see text).
Figure 9.2 identifies functional links between the three key players in the education market and six systems innovations which relate to the interfaces between employer, college and student. The three case studies (Chapters 3, 4 and 5) included a range of examples of the application of such facilities.

The fact that in health care education, education providers normally work closely with both employer and student gives them the opportunity to work towards an ideal in which through the operation of programmes, both individual and organizational needs are met. Chapter 5, in particular, described a development which has had some success in resolving the apparent contradictions that sometimes appear to exist between the educational needs of employer and student. In an ideal instrumental, market-led situation, education and training will recognize and work towards meeting the needs of both.

Validation and operation

These last two stages in the curriculum development model involve checking the relationship between client need and curriculum design. Although validation (as a stage in this model) includes normal course validation and/or accreditation procedures it also should involve a check by the development team against the initial concept (articulated in the planning stage) and the anticipated cost–revenue relationship. At best these checks involve potential consumers and purchasers.

Once these things are confirmed a promotional campaign can be developed to ensure that the benefits of the product are communicated to prospective students and/or purchasers. Chapter 5 has illustrated this process.

During the operational stage, evaluation processes should monitor fitness for purpose in addition to conventional aspects of academic and professional standards.

In the health promotion course for nurses considered above Kelly and Maloney (1992) based the approach taken in course evaluation on a model of behavioural change. In this case, a theory of self-development identified success in, for instance, giving up smoking to involve both a 'self-driven' behaviour change combined with a change in social identity (from smoker to non-smoker). Evaluation therefore involved assessment of both the extent to which people came to desire to break the habit and the extent to which they were in fact able to do this. It is interesting here that the instrumental nature of the course was reflected in both development and evaluation. The latter being directly linked to the objectives of the programme rather than just measuring its 'entertainment value and technical operation'.

THE ROLE OF THE PROFESSIONAL EDUCATOR

A major implication of these approaches to education and training is the high levels and range of skills required from professional educators. In addition to
systematic and objective ways of identifying necessary coverage, the curriculum
developer must ideally have a good working knowledge of costing, applied
human sciences, curriculum systems and an inclination to innovate. In addition,
the professional educator must contribute effectively to the operation of the re­
sulting programmes and contribute in other ways to the operation and develop­
ment of the college. This sort of challenge cannot merely be an appendage to the
skills of the professional nurse or other health care provider. To be most
effective the education professional must perceive her/himself as such.

Many would argue (myself included) that the effective health care educator
maintains a direct involvement with patients. However this should no longer be
an end in itself but rather a means to an end – that end being to effectively
deliver health care education. It is a perennial problem with teachers (at least in
post-compulsory education) that they tend to retain a primary affiliation with
their first career (engineer, scientist, nurse, etc.) rather than their second (educa­
tion). This stance may be less problematic in a period of professional stability
but is of limited use at times when education could be contributing to significant
institutional, professional and organizational change. Bearing in mind the dis­
cussions earlier in this chapter, it is not surprising to find professional groups
(e.g. RCN, 1993) arguing as if the profession of (for instance) nurse and the
profession of educator constituted subsets of one profession. However, as I have
argued, it is questionable whether the professional interests of the one are com­
patible with the change agent role of the other.

Furthermore, the fact that a nurse tutor is not primarily a nurse is not only a
matter of professional stance. Increasingly, as nurse education is removed from
health authorities, so nurse tutors become legally separated from the organiza­
tion whose clients are patients. It has been shown in Chapter 7 that the nurse
tutor who considers patients to be her/his clients is both rejecting the position of
professional educator and exhibiting a misinterpretation of reality. While it is
ture that the education of health professionals is a critical factor in the delivery
of health care to patients, the relationship is indirect and there are in reality only
two clients – the students and the employing organizations. This position essen­
tially means that the service provider is increasingly the primary client of the
education provider, at least with regard to WP10-funded contracts. A simplistic
response to this circumstance would be to suggest that an education provider
must do whatever the purchasing client says. However, this presupposes that
service providers are in a position to specify the nature of the education services
which would meet their needs. It is more likely however that at best they will
simply know what they are trying to achieve!

Consider, for example, an advertising agency working for a large corporate
organization (the client) in a service industry. Assuming the client organization is
well established and internally coherent, it will know exactly what it wants to
achieve through advertising (e.g. 5% increase in sales). However, although it
may have some required features, it will not be in a position to specify the detailed
nature of an advertising campaign, nor would it be in a position to implement it.
Any company that was inclined and able to design, specify and implement the campaign would be unlikely to employ an advertising agency. If over time the agency did indeed contribute effectively to the client’s goals, then it would be retained. If it did not, it would be vulnerable and if for some reason it showed little response to the client’s priorities, it would certainly lose the contract. In the same way, there is in the new environment an implied onus on education providers to recognize the nature of their relationship with service providers, to understand their goals and difficulties and to come up with education services designed, recommended and operated on the basis of that understanding.

A major and general challenge for the designers of vocational curricula is therefore to identify the needs of the employers. Wellington (1993), having reviewed a number of surveys into employer’s perceptions, suggested that ‘the needs of employers are complex and not always immediately tangible’. He found their statement of needs to ‘contain a conceptual mixture of attributes, qualities, dispositions, attitudes, competences and general skills’ and observed that their stated needs did not always coincide with their actual practices. Because of this, superficial attempts at employer liaison through advisory committees or employer involvement in curriculum teams are of little real use except perhaps at strategic level or as public relations (see Chapter 8 for a more profound attempt to keep in touch with clients).

Although the surveys considered by Wellington related to ‘industry’ in general (i.e. a range of industries) the point is nevertheless valid that organizations rarely have the time or skills to articulate their needs in such a way as to provide an adequate basis for curriculum development. Certain aspects of the situation in health care education would, however, seem to alleviate the problem. Firstly, a consistency of need could derive from the broadly similar occupations found across a range of employers (e.g. nurse, midwife, physiotherapist) and secondly, many of these occupations are professions regulated in various ways by professional and statutory bodies. Educationalists however should be very cautious of deriving reassurance from the professional regulation of occupations. In the first place, there are often an enormous range of possibilities for local focus, which fall within the broad requirements of a professional or statutory body, and secondly, the existence of professional regulation can, for educators trying to identify and respond to corporate needs, create more tensions and difficulties than they solve. As we have seen, resolution of such tensions is a part of curriculum development.

This view of health care education may not please many. Set in an instrumental context, the work is judged on nothing more than its utility. Furthermore the educator is not accountable to patients but to students and client organizations. In Anglo Saxon culture, notions of applied knowledge and utility carry negative connotations (Glover and Kelly, 1987) compared to purely ‘academic’ pursuits. While health care professionals carry their own special status derived from direct contact with patients, the educator qua educator may work only indirectly for patient benefit and, as the role has been articulated here, it might be judged
to have been diminished. However, it has been shown that the instrumentally based education and training of corporate professionals is highly demanding. It is based on a multidisciplinary range of skills and knowledge; it requires sophisticated educational practice. There is no place for ideological indulgence, school-derived orthodoxies, sacred cows or anachronistic dogmas. To that extent, at least, the new fire of corporate instrumentalism may be no worse than the old frying pan of institutionalized professional interest. Time will tell.

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Paradigms of Practice:
a dilemma for nurse educators

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ABSTRACT In the United Kingdom's newly reorganised National Health Service (NHS), Regional Health Authorities (RHAs) currently have responsibility for purchasing education services from colleges or, increasingly, universities. This purchasing relationship is the key element in a new market for education which has replaced the bureaucratic control of the old NHS. In making purchasing decisions RHAs are acting to secure workforce supply (and/or professional development services) for the newly autonomous employers (NHS Trusts) who through hospital or community services provide for the health care needs of the public. This paper analyses the market for health care education in terms of the distribution of power between key players. It argues that the local purchasers (currently Regions) and recipients of the products of nurse education (NHS Trusts) now exert levels of control which are unique in the field of post-compulsory education and training in the UK. As universities pick up the business of nurse education the nurse teacher is simultaneously drawn in various directions. It is argued that the reconciliation of new tensions in the role of the nurse teacher is not simply a function of the philosophical compatibility of competing priorities. Rather, the location of power in the hands of relatively small numbers of large purchasers and employers may effect a radical change towards instrumentalist ideologies, at the expense of orthodox approaches to education. From an analysis of various models of the nurse teacher, it is postulated that the currently established 'paradigm of practice' may be threatened by an incipient new paradigm, which, while it may be more suited to the market, is incompatible with current professional values.

Introduction
The general reorganisation of the United Kingdom's National Health Service (NHS) has raised various issues for education. With the creation of an internal market for health services, the traditional position of colleges within District Health Authorities (DHAs) has become incompatible with the latter's main new function as purchasers of health services from NHS Trusts. The anomalous nature of this position had, due to earlier Project 2000 reforms (UKCC, 1986), a ready-made solution. The Project 2000 report had recommended that the initial training of nurses should lead to
higher education awards and, as a consequence, colleges of health care education developed curriculum-focused partnerships with higher education institutions such as universities. So when general NHS reorganisation left colleges with no clearly appropriate parent organisation within the NHS – with links already developed, the incorporation of colleges into universities became a favoured option. Thus Regional Health Authorities (RHAs) are currently positioned as purchasers of education on behalf of NHS Trusts, with universities increasingly being providers of education and training services. In line with 'Working Paper 10' (HMSO, 1989), major contracts must be agreed between these two sides of an incipient market. Unlike the internal market for health care provision, this education market then is the result of the combined effects of policy developments driven mainly by the general financial and other imperatives of NHS reform.

A critical factor in the functioning of this market will be the long-term control of funding for education along with the ways in which the market is managed. In any event, and regardless of the anticipated demise of RHAs, a new stability is emerging in which NHS Trusts must increasingly be perceived as the clients of the universities and, as has been argued elsewhere, these two influential, independent and 'corporate' sectors represent main players in the future of English nurse education (Humphreys, 1993).

The Redistribution of Power

Spurgeon (1993) has described the NHS as a 'provider-dominated organisation' in which professional views of the appropriateness of services have remained ascendant. As a manager he complains that the nature and structure of the NHS have enabled such groups to powerfully resist changes even when not consciously antagonistic to them. The idea of considerable power residing with professional groups is not new; indeed for some, power constitutes a defining attribute of the professions. Parkin (1979) for example defined professions on the basis of their success in establishing legal monopolies by means of state licensure. Although Parkin argued from a Marxist standpoint, many other social scientists have reached similar conclusions based on the Weberian concept of 'social closure' by which social groups seek to restrict access to specific opportunities (such as the opportunity to practise) (Weber, 1968). Essentially, adherents to this approach to the sociology of the professions tend to define professionalism simply as an occupational strategy to control the market for particular services.

In the pre-reorganisation health service the state acknowledged (and indeed facilitated) the monopolies of the health care professions and defined the clientele (all citizens). By and large, however, the professions continued to determine the needs of the patients and the manner in which
these needs are catered for. Johnson (1972) has defined professions as occupations which keep control of these two aspects of the provider-consumer relationship. The fact that the state (through the NHS) mediates the relationship between the health care professional and the patient does not, therefore, necessarily encroach on professional power — in fact such mediation can enhance the professional monopoly and guarantee a universal clientele.

State mediation between the 'providers' and the 'consumers' has, therefore been broadly beneficial to the professions involved. Furthermore, it can be argued that the creation of the internal market leaves these key elements of state mediation largely intact. However, it is clear that there has been and will continue to be a considerable effect on the deployment patterns and efficiency of health services stemming directly from the new need to secure the patronage of purchasing District Health Authorities and other purchasers. In this context newly corporate NHS Trusts will strive to secure contracts. To the extent that Trust executives are not all health care professionals so the power of the professional groups is counterbalanced by a new type of official (the general manager in a corporate setting). Furthermore, even professionals, when put in the position of being measured against corporate rather than professional criteria of success, may change their position. In such ways the Trusts operating in a market will constitute an increasingly significant location of power outside the professional groups. The creation of the internal market for health services, and the consequent location of power in the hands of 'purchasers', has, therefore, been regarded as providing a potential counterbalancing force to the power of the health service professions (Ham, 1991).

Continuing our Weberian analysis, we may identify both professional groups and corporate organisations as organised bureaucracies. Although different in character from the massive state bureaucracies, these smaller bureaucracies have in common a tendency to perpetuate themselves. For the corporate organisation this tendency is normally explicit. Operating in a market, they will make large-scale decisions with the aim of securing their positions through combinations of advantageous activities. This is the objective of strategic planning.

Organised occupational groups may effect the same ends but by different means. Professions in particular are likely to resist any steps which might endanger the size or power of their membership. Often however, this tendency is not explicit, instead the benefits to clients or society are cited as a rationale for the status quo. As Johnson (1972) has argued, such altruistic motivation may be entirely genuine but it serves also as legitimation of professional privilege. Whether such tendencies amongst organised professions work to the interests of their consumers is a moot point. Although arguments tend to be vociferous, there is, as Saks (1983) has pointed out, often a lack of real evidence on which to base
secure conclusions. The tendency to self-perpetuation of health care professions and NHS Trusts, probably represents the limit to their similarity. In particular they can be broadly contrasted in terms of their responses to change. Whereas professional groups may be highly innovative in terms of clinical practice, many aspects of professionalism (including professional education which is discussed later) suggest complex and tenacious value systems and a resistance to externally initiated change. For corporate organisations, however, externally driven change tends to be an accepted way of life. As Druker has observed, “Every organisation has to prepare for the abandonment of everything it does” (cited by Jacques, 1994).

The essence of the current health service reorganisation in England involves a shift from direct governmental coordination of health services through a massive state bureaucracy to coordination through the operation of ‘internal’ markets. It is hoped that by this means the inefficiency thought by some to be characteristic of state bureaucracies will be reduced. The Trusts constitute the vehicles in which such inefficiencies are to be addressed. Indeed the strategic changes in Trusts trying to survive in competitive and volatile markets are generating severe tensions with professional value systems. New financial constraints and the possible erosion of professional power bases or radical skills repprofiling of the workforce create a large potential for conflict.

It is this mismatch between professional and corporate imperatives that, it will be argued, creates a major dilemma for nurse education. Formerly part of a single large bureaucracy the nurse and the nurse teacher constituted sub-sets of the same profession. Education was fundamentally ‘in-house’ in terms of the legal employment of both the educator and educated, and, metaphorically, with regard to the fundamentally consistent professional imperatives of dominant occupational groups. In the reorganised health service, however, nurse educators are increasingly distinct from the mainstream profession. They are often employed outside the NHS and crucially theirs is a different market. For while the Trust must secure patronage from DHAs etc., the university must effectively secure patronage from Trusts – and as we have seen it is the Trusts that have been put in place to erode the ascendancy of those professions from whom the educators are drawn.

Four Models of Nurse Teacher

With the advent of WP10, control of the services of nurse teachers also passed from a state bureaucracy to a quasi-market. While the market replaces state bureaucracy so state mediation between education and the workplace is reduced. Increasingly the nature and amount of education will be determined by the demands of new Trust employers on the basis of workforce supply and strategic development needs. In this market,
state mediation (of a sort) currently continues by virtue of the fact that contracting for education is still the business of RHAs and the statutory bodies still hold qualitative responsibilities. However, in this environment Regions are coming to acknowledge the legitimacy of considerable Trust influence on contracting, and many are systematically determining Trust views on education (Walters & Macleod Clark, 1993a,b), or even developing mechanisms for the devolution of contracting decisions to consortia of NHS Trusts (Humphreys et al, 1993; Humphreys & Davis, 1995). With the coordination of education now located in a market mechanism, and power significantly in the hands of large corporate patrons, the function of nurse education needs re-evaluation from first principles. Before examining this however, it is necessary to acknowledge the significance of the universities in terms of their increasing influence as new providers.

The involvement of universities through P2000 has preceded the general reorganisation of the health service (although both developments are still ongoing). This development alone has had significant effects on education and the role of the nurse teacher because of the new curricula (Crotty, 1993a). The funding of P2000, however, did not bring the universities directly into the market; instead the colleges of nursing led funding bids in which the universities had little to lose from participation. In contrast the incorporation of colleges into universities draws them into the centre of the health care education market. For universities, with the assets of new faculties, such as Nurse Teachers and sometimes buildings, come the liabilities and risks of a volatile market. As corporate organisations themselves, universities, like Trust, act strategically. Increasingly they will be a force in nurse education above and beyond their established curriculum involvement.

A major issue for nurse education is the compatibility of the interests of each significant component of the new health care education environment.

Figure 1 identifies four such components; two are established: the profession and the student; and two are new: the Trust and the university. For our present purposes it is constructive to analyse the model of nurse teacher implied by each of the four components. Consider first the pre-reorganisation environment represented by the right side of Figure 1. The education of professionals characteristically includes the acquisition of complex value systems in addition to specialised knowledge and skills (Houle, 1980). Simpson (1967) showed how, through a process of socialisation, student nurses come to share the professional orientation towards the workplace. As a consequence of this process the student enters the profession. Since the student is a putative professional this process of socialisation is reasonably satisfactory to both parties. The student becomes a nurse and the profession receives another member imbued with the required skills and professional values.
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In this conventional pre-reorganisation scenario the teachers' primary allegiance was consistently informed by the fact that they worked within the Health Service and were employed by an organisation (i.e. the DHA) whose main consumers were patients. There is a sense in which her/his training as a teacher constituted one of the specialisms an experienced nurse might follow. In this way the profession of nurse teacher can be seen as essentially a sub-set of the profession of nurse and with a major process of education being socialisation, the roles of nurse (first) and educator (second) are compatible.

The reorganised health service however introduces two new elements with less compatible characteristics for the nurse teacher. Furthermore these new elements occupy crucial positions (the university as employer and the Trust as client). With these new organisations come different priorities, values and demands. Among the many roles of university teaching staff that of 'academic' is traditionally important. Such staff are expected to conduct research and to publish. Furthermore, although university education must also be considered a process of socialisation, the ethos of some universities at least carries encouragement to question orthodox beliefs and, in some cases, by implication, to subvert establishment values. Indeed, such questioning is generally considered (by academics at least) a positive aspect of university life. In addition to this cultural aspect and more directly...
significant perhaps are the possible long-term effects of university values and the resulting content and emphasis of pre-registration programmes. It is possible in some cases to anticipate a process of academisation of curricula in which the theoretical is emphasised in favour of the vocational, or at least one in which the theoretical becomes more clearly distinct in curricula and, therefore, potentially less well integrated with practice elements.

Nurse teacher as 'academic' is possible in many ways to reconcile with the established models of nurse teacher as 'nurse' and nurse teacher as 'educator'. Even the idea of subversion is mildly consistent with modern concepts of the professional which emphasise life-long learning, initiative and a tendency to reflect on practice and innovate. However, the involvement of universities carries more ambiguous implications for the statutory national boards by placing greater power in the hands of large academic institutions. As Johnson (1972) has remarked, while these 'academic' institutions may themselves be staffed by members of the occupational group, such events can nevertheless change the distribution of power. (A shift which he regards can be at the expense of the practising membership.)

Furthermore the association of universities with academic values should not be taken to imply a naivety with regard to education markets. Like the NHS Trusts the universities are corporate organisations increasingly experienced in strategic manoeuvres. The English and Welsh university sector, including now the former polytechnics, has significant experience of markets, and contracting systems which put a premium on efficiency. Also, like the Trusts the universities have had to re-evaluate strongly held values which are not necessarily shared by purchasers of education. Whether the strategically minded corporate universities can all continue to prioritize their scholarly or academic character remains to be seen. In any event, depending on the institution concerned including their experience in applied research and professional training, it is likely that many such universities could make an effective response to either Trust or professional priorities, or, in so far as they are compatible, both.

The final and most challenging model of nurse teacher is that derived from the Trusts. We have considered above how corporate organisations tend to be explicit about their strategic priorities. Management literature on education and training, whether pre-service or in-service, tends to link it directly to consequent benefit with regard to organisational priorities (e.g. Fill & Mullins, 1990) and as such they are considered (potentially at least) as a key element in the facilitation of change and consequently an investment in the long-term survival of the organisation. From the managerial standpoint, education may legitimately be asked to develop the actual or prospective workforce in terms not only of knowledge and skills but also values and attitudes (Mullins, 1993). Furthermore, there is evidence that these ideas are informing the responses of Trust managers...
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both in terms of recruitment of newly trained staff and their in-service training. Nettel (1993), for example, has reported the introduction of training initiatives related to the market, culture and overall organisational change, through which 'every member of staff' becomes clear about their role. For our present purposes such instrumental approaches to education we will call training, and the associated model of practice as nurse teacher as 'trainer'.

Thus we have four models of the nurse teacher:

1. Nurse teacher as nurse.
2. Nurse teacher as educator.
3. Nurse teacher as academic.
4. Nurse teacher as trainer.

We have seen that some of these models at least may not be entirely incompatible and, of course, in any such analysis there are considerable overlaps. In so far as this is true, any implicit priorities, values and approaches to education, common to more than one model, may in principle be unproblematically located in the paradigm of educational practice adopted by the nurse teacher. Indeed the reconciliation of different models has received some coverage in the literature (e.g. D'A Slevin, 1993) including some doubt as to whether the consequent workload on nurse educators is feasible (Crotty, 1993b).

The theoretical or philosophical compatibility of the models Is not the only issue, however. The reality must acknowledge the distribution of power in the system. It is in this respect that nurse education has become unique. In comparing the funding of nurse education with other vocational areas represented in further and higher education, Bailey & Humphreys (1994) identified an unprecedented degree of power located in the hands of purchasers. This analysis derives from the local nature of funding (i.e. Region or Trust controlled, as opposed to routing through a centralised national body) combined with the largely monotechnic nature of nurse education institutions. With few specialities (often just nursing and midwifery) colleges (or faculties) seek small numbers of very large annual contracts on which their solvency depends. Furthermore, all significant contracts may derive from a single purchaser who delegates the decision or at least gives considerable influence to small numbers of large employers. This degree of local purchaser-power creates real dilemmas for managers and practitioners in nurse education. In particular the ability to achieve an eclectic compromise by the manipulation and attempted reconciliation of the different models of nurse teacher may be severely limited by the effects of a market in which purchasers are increasingly assertive and uniquely powerful, with the result that the instrumental model (i.e. nurse teacher as trainer) may need to be prioritised to an extent incompatible with the other three models.
Control and the Paradigms of Education Practice

We have seen above how markets can be regarded as constituting an alternative mechanism of social coordination to state bureaucracies. In the context of nurse education, decisions formerly made by 'state' officials in health authorities are increasingly made or influenced by large corporate employers. In the market for health care education, as the state reduces the scope of its direct involvements, political authority is to an extent replaced by voluntary exchange (i.e. purchasing decisions) as the primary means of control.

In parallel with other bureaucratically organised education systems the ideologies of nurse education have tended to be non-instrumental. The depth of this commitment is revealed by the current literature on nurse education. Textbooks consistently see the function of nurse education in the context of social benefit or other concepts which by their nature omit any consideration of corporate employers. Pendleton (1991) has for example expressed the view that the educational ideology of 'reconstructionism' (see Scrimshaw, 1983) is most relevant for nurse education since nurses, because of their position and experience, can be seen to be at the forefront of those who work for social justice. Similarly Rolfe & Jasper (1993) subscribe to a 'humanistic' ideology focusing on the desire of students to grow and develop. These views exemplify the values and aspirations of 'altruistic' professions and tend to neglect corporate Trust imperatives.

Furthermore the extent to which the significance of Trusts is not being assimilated by nurse educators is illustrated by discussions of marketing which distort the reality of the market to the point where patients are still considered clients of education (Webster, 1990). (A position which has been described above and elsewhere (Humphreys, 1993) as incompatible with any objective analysis of the health care education market.) As we have seen, however, in a state bureaucracy in which both nurses and nurse educators are employed by District Health Authorities, there was logic to this stance.

This tenacity with which some nurse educators maintain increasingly anachronistic stances has been the basis of an examination of these received beliefs in terms of Kuhnian paradigms (Humphreys & Quinn, 1994). Through examining the history of science, Kuhn (1970) came to the belief that professional scientists operated within a dominant conceptual framework of received beliefs which the community acknowledged as supplying the foundation for its practice. These received beliefs he called the paradigm. Based on Fleck's original idea of 'thought styles' (see Harre, 1993) the paradigm enshrined values, methods of work and fundamental concepts. In the main, professional scientists spent their time solving problems set in the context of the paradigm. Interestingly, Kuhn
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considered the paradigm to be dogma to some degree, maintained through social pressure and education, which through socialisation ensured like-minded new recruits to the profession. Furthermore he identified how evidence or analyses inconsistent with the paradigm would be unlikely to find their way into textbooks or indeed journals. There is a sense in which many nurse educators are still conducting their practice within a paradigm developed in the context of professional services mediated through the operation of a state bureaucracy.

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<tr>
<th>Characteristics of Education Provision which provide the context for the paradigm</th>
<th>A</th>
<th>B</th>
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<tr>
<td>Internal to NHS</td>
<td>&quot;In-house&quot; DHA function</td>
<td>Outside NHS</td>
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<tr>
<td>Nurse tutor as NHS employee</td>
<td>Assured involvement</td>
<td>Nurse Teacher as employee of corporate University</td>
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<th>Primary Concerns and implied models of nurse teacher (in priority order)</th>
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<tr>
<td>1 The profession (Nurse Teacher as nurse)</td>
<td>1 The corporate client (Nurse Teacher as trainer)</td>
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<tr>
<td>2 The patient (Nurse Teacher as nurse)</td>
<td>2 The student (Nurse Teacher as Educator)</td>
<td></td>
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<tr>
<td>3 The student (Nurse Teacher as Educator)</td>
<td>3 The profession (Nurse Teacher as nurse)</td>
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<tr>
<th>Educational Ideologies</th>
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<tr>
<td>Various (see Scrimshaw 1983)</td>
<td>Instrumental</td>
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<th>Values</th>
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<td>Patient as client of education</td>
<td>NHS Trust as client of education</td>
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<td>Education as entry to profession</td>
<td>Education as workforce supply</td>
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<td>Student as putative professional</td>
<td>Student as consumer</td>
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<th>Methods of Work</th>
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<td>- Curriculum derivation</td>
<td>Professional regulation</td>
<td>Market demands</td>
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<td>Epistemological analysis</td>
<td>Training needs analysis</td>
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<td></td>
<td>&quot;Profession-led&quot; curriculum development</td>
<td>&quot;Trust-led&quot; curriculum development</td>
</tr>
<tr>
<td>- Aspects of Process</td>
<td>Teacher as socialisation agent</td>
<td>Teacher as change agent</td>
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Table I. Some features of two alternative paradigms of nurse education. Paradigm A is considered to represent the established position developed in the context of an NHS bureaucracy. It draws its values from professional priorities. In a new education market the emergence of a new paradigm (B) is postulated. (Adapted and developed from Humphreys & Quinn, 1994.)
Table I, Column A lists some of the primary concerns, values and methods of work which appear to be characteristic of this paradigm. As Quinn (1994) has observed this paradigm relies heavily on curriculum models derived from that other established state bureaucracy, the school sector.

In the context of health service reorganisation, the incorporation of colleges into universities, and the development of the education market, it is inconceivable that these practices in health care education can survive unchanged. Furthermore, there is increasing evidence of a shift in the practice of nurse education which accommodates the corporate needs of NHS Trusts. While it is too early to identify the exact local triggers and the extent of the shift, alternative approaches significantly influenced by the market and the nurse teacher as 'trainer' model (as defined above) are beginning to emerge. These approaches, which have not yet found their way into the literature, have no doubt been encouraged by increasing awareness of significant market effects. Although variations in the way RHAs currently manage the market have led to its effects being up to now variable across the country, there have already been catastrophic losses of business for some education providers, who are no longer involved. Other lesser effects which can be linked causally to market mechanisms have included teaching staff redeployment and redundancies. Trusts, not confident in the ability (or in some cases even inclination) of conventional educators to address their needs, are in some cases establishing in-house training centres for the purposes of post-registration staff development. In any event, as evidence of a mismatch between education practices and the priorities of employers accumulate (Elkan & Robinson, 1993) national boards are beginning to acknowledge the importance of Trust priorities (albeit inconsistently) for the first time (ENB, 1993), and curriculum developments based on credit-based flexible learning systems appear to be facilitating a degree of response to employers' priorities in those educationalists inclined to accommodate them.

Drawing on the as yet sporadic evidence, along with training systems established elsewhere in the post compulsory sector, it is possible to postulate tentatively the existence of an emergent new paradigm of nurse education, some of whose basic concerns, values and methods are listed in Column B of Table I. While the reality of this paradigm at present constitutes merely an hypothesis, it is certainly the case, that in an environment of corporate priorities and managed markets, health care education professionals are now faced with a range of difficult dilemmas concerning their role. Examination of the top two 'primary concerns', of each paradigm (Table I) gives an indication of the nature of the dilemmas and the tensions inherent in the prospect of a transition from (A) to (B). In paradigm (B), the strength of commitment to the professional community and its particular values of caring for patients implies a perception of the teacher as above all a subset of the profession of nurse. The new
paradigm however breaks with this tradition. Such a break may certainly be necessary if teachers are to act as change agents contributing to the strategic development of Trusts. This is because change may threaten the coherence of existing professional groupings (e.g. skills reprofiling) or the boundaries between previously distinct practitioners or indeed contribute to significant value changes (efficiency, resource-management and care within strictly finite budgets).

Interestingly, for these reasons, combined with the great range of additional skills that the teacher will need in order to offer a full service to Trust clients (e.g. training needs analysis, market research), the effect of the market may be to establish nurse teachers as a more distinct professional group rather than simply as specialist nurses. In this context, with nurse education already increasingly outside the NHS, it is interesting to note that national boards are giving up their control over the funding of nurse teacher training. The idea that emerges of a more distinct profession of nurse teacher not so committed to the values and priorities of the profession of nurse also emerges in this analysis from the greater priority given to the student. The positioning of the student as only third in the order of primary concerns in the established paradigm (A) may be regarded as contentious but it is implied by any system in which education controlled by the professional group serves as entry to that profession. The relegation of professional (nurse) concerns to third priority in paradigm (B) should not be taken to imply that the nurse teacher would not maintain her expertise through direct and ongoing contact with clinical areas or indeed patients. Rather, it suggests such contacts to be educationally driven either for gaining insights in terms for example of training needs analysis or to maintain expertise and clinical skills through what school teacher trainers refer to as 'recent and relevant' experience. Thus, working in clinical areas is not an end in itself (as it is for nurses) but a means to an end – that end being the provision of effective education services. Table I does not identify the model of nurse teacher as 'academic' in either paradigm. In fact the university influence on nurse education would, as we have seen, be compatible with either paradigm. Alternatively the higher education sector, having only recently abolished the binary divide (between universities and polytechnics) may not yet represent a consistent influence on the direction of nurse education.

The Future

It has been argued that the replacement of the bureaucratic coordination of health care education with quasi-market mechanisms shifts the balance of power from professional groups and even statutory bodies towards the corporate NHS Trusts. This in turn implies new and ultimately instrumental approaches which the existing paradigm of education
practice cannot accommodate. The present analysis suggests that, in a developing market for education essentially similar to that currently in place, one of two possible alternatives will emerge. Either current practitioners of nurse education will significantly change their practice, or the market will effect the replacement of them with new providers. Either way the orthodox paradigm of education practice although tenaciously defended by many educators is increasingly being perceived as anachronistic and inadequate. It seems likely that the new market paradigm will demand fundamentally instrumental ideological underpinnings and possibly show many of the characteristics of Table I, Column B. In trying to resolve the tensions now inherent in nurse education, nurse teachers and their managers must decide which way to go with regard to their own professional practice. In reforming the role of the nurse teacher they will implicitly or otherwise be reflecting on the traditions, values and priorities of different models of nurse teacher. This in turn will lead them to models of curriculum, curriculum development and teaching and learning processes which will underpin their future services to Trusts. It is not at present possible to anticipate the rate or the pattern of change across the country. The demise of regions could either facilitate the process by increasing delegation to Trusts or, conversely, consolidate professional power through a centralised bureaucracy (depending on the policy of the NHS management executive). It is possible also to conceive of a radical change in education funding (such as a transfer of control to the Department for Education) which would dramatically alter the anticipated course of events. It is also quite possible, however, that the nature of the paradigm adopted by existing health care education practitioners may determine the ability of their institutions to remain involved. Furthermore, assuming continued local control of funding, effective responses in one area may be ineffective elsewhere. These decisions by nurse educators individually and collectively may well constitute an important influence on the future picture of nurse education in this country.

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References
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British National Health Service trust chief executives on nurse education: corporate instrumentalism and doubts on quasi-market structure

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INTRODUCTION

Traditionally the British National Health Service (NHS) combines public financing with public ownership of facilities. Essentially money raised by the British government through taxation is used to provide a relatively comprehensive health service delivered by state-owned hospitals and other provider facilities. For most developed countries the demand for health care exceeds the supply of resources. In the United Kingdom (UK) this gap widened during the 1980s to the point where the potential for the consumption of tax revenue brought NHS reform to the top of the British (Conservative Party) government's agenda (Ham 1992).

Internationally various models of health care funding and delivery exist. While public funding of comprehensive
health services is not unique to Britain (Canada and Sweden being other examples) the alternative of private funding is also available. In the USA funding through private insurance enables public funding to be restricted to poor or elderly people. Furthermore, even the retention of comprehensive public funding need not imply public ownership of facilities. The Netherlands, for example, combines largely public funding with non-profit but privately owned hospitals. (Ham et al. 1990)

In due course and despite such alternative models, the British government decided to retain the traditional NHS principles of public finance with public ownership and concentrate instead on efficiency. The NHS and Community Care Act 1990 can therefore be seen as an attempt to increase the efficiency of the NHS set in the context of a general policy trend towards the introduction of market forces into the provision of welfare services. This Act created the so-called 'internal market', in which purchasers and providers generally remained within the NHS but were made distinct. One of the most significant elements in the reforms was the creation of relatively independent non-profit NHS trusts. These new corporate providers were split off from the old district health authorities (DHAs), which assumed the role of purchasers.

**Control of nurse education**

Prior to this reform the education and training of nurses had largely been provided in-house; that is to say the DHA typically contained within it facilities both for the delivery of health care and the training of nurses. Although not primarily concerned with nurse education, the NHS and Community Care Act 1990 carried the radical effect of breaking this long standing 'in-house' model. In the event, concurrent Project 2000 educational reforms, which positioned nurse training as a higher education activity [United Kingdom Central Council (UKCC) 1987], acted synergistically with general NHS reform with the result that many schools of nursing have now been taken out of the NHS and located within corporate education provider organizations, i.e. universities (Humphreys & Quinn 1994).

The question of who should control the financing of nurse education once colleges were removed from DHAs was anticipated by the Department of Health, who in 1989 published Working Paper 10 (WP10). This replaced a complex and bureaucratic funding system, involving national boards among other organizations (Humphreys 1993), with a rationalized and ring-fenced system of purchasing controlled by regional health authorities (RHAs) (in England) whose duty it became to ensure a sufficient supply of qualified nurses for the NHS trusts (and other service providers) within their boundaries: so-called regional self-sufficiency. (Arrangements are slightly different in the other three countries in the UK, but are similar in principle.)

In the event, it can be argued that NHS reform has involved the creation of at least two markets — one for health care services (as a direct result of the 1990 Act), and another for education services due to the combined effect of various policy developments including Project 2000 and NHS reform. While the health service market has rightly been subjected to a high degree of academic and political scrutiny, the smaller education market has been largely neglected in this respect, yet in the region of £600 million of public money is spent annually (NHS Management Executive 1994).

Like many of the new public sector purchasing arrangements, the market for education can be considered a 'quasi-market' because it differs from conventional markets in various significant ways. As DHA colleges move into or are replaced by universities, the supply side is increasingly characterized by independent corporate providers competing (to various extents) for the business of education. However, unlike conventional markets, the providers are generally non-profit organizations. Furthermore, on the demand side, commissioning is located in a purchasing agency (currently the RHA) which is not the direct user of the service.

While these features identify the education market as 'quasi' (Le Grand & Bartlett 1993), there are important contrasts between nurse education and the major welfare state services that are now co-ordinated through markets. In particular, the demand side is complex in education, as in addition to individual 'consumers' (pre- and in-service students) there are major corporate organizations who are arguably the effective recipients of workforce supply or professional development services (the NHS trusts). It has been argued elsewhere (Humphreys 1993) that the WP10 quasi-market locates more power with trust 'clients' than with student consumers. Furthermore, Bailey & Humphreys (1994) have argued that the involvement of regional rather than national purchasing organizations makes trust influence over education potentially much greater than is typical of other types of employers whose training is conducted by public sector higher education corporations.

In this context, various RHAs have been developing ways of managing the WP10 market to allow or encourage NHS trust involvement in purchasing decisions. Such arrangements include those developed for the South East Thames RHA (now part of the South Thames RHA) reported recently in the Journal of Advanced Nursing (Humphreys & Davis 1995). In this system individual trusts report on qualitative aspects of education provision and advise regional purchasers via consortium configurations. Because the system makes explicit links between quality (as defined by trusts) and contracting decisions, it has been developed and operated under the acronym QUACE (Quality Assurance for Contracting of Education). The QUACE system was developed as a research and development project by the School of Post Compulsory Education

It was based on an initial research phase in which the views of NHS trusts on education were sought. This work built on an earlier survey commissioned by SETRHA and reported by Walters & Macleod-Clark (1993a, b). In particular, views were sought from more senior levels within trusts than the earlier work, and a more quantitative method was employed. Also, at this point of the development, it was possible to seek specific information from trusts on the types of educational quality evaluation which they would have confidence in.

THE STUDY

This paper reports the results of the empirical work on which certain design features of the QUACE system were based (the system is currently being introduced in the eastern part of the South East Thames RHA). The work, however, also carries a more general interest in that it reveals certain consistencies in the views of NHS trust chief executives (and senior executive nurses) of significance in the current quasi-market arrangements.

Method

The primary purpose of the study was to survey the views of NHS trust chief executives although, for comparative purposes and in order to link back to the earlier study, senior executive nurses were also surveyed.

Two groups of NHS trust staff were therefore questioned: chief executives (n = 15) and senior executive nurses (n = 14). The latter group included professionally qualified nurses operating at clinical director equivalent level or above. Of the chief executives, two had clinical backgrounds, the others having general management experience only. Nine chief executives were from acute and six from community trusts.

Each chief executive was interviewed on a one-to-one basis for about 1¼ hours. The interviews were semi-structured, with standardization (May 1993) being achieved through the use of an interview schedule, including both closed response and open-ended questions. In addition to a standard introduction (read to the subject) the schedule included three sections, each investigating a different area as follows.

Section A: basic information about the subject

This section included information about their employer, job title, background (clinical/general management) and certain aspects of their organizational setting.

Section B: matters of importance with regard to education

This section consisted of statements to be rated on a Likert scale (1–5) according to the subject’s perception of their importance with regard to education (5 = highly important), along with two open questions soliciting information on other matters considered significant to the study. These statements were largely based on the earlier semi-structured interviews reported by Walters & Macleod-Clark (1993a, b) also conducted for the region. Each statement concerned a matter raised in the earlier interviews (at ‘nurse manager’ level) as a desirable feature of education. The use of a Likert scale was designed to achieve a more sensitive measure of perceived importance and relative priorities through ranking of positive responses.

Section C: features of educational evaluation

This section included statements on the evaluation of education services, which subjects were asked to rate their agreement with, also on a 5-point Likert scale (5 = high agreement), along with one open question on evaluation and some information-seeking questions regarding WP10 lead officers and their work.

Each interview session was conducted by one of three experienced and fully briefed researchers. At the end of the specified questions, researchers conducted a general discussion, picking up particular points of interest raised by the subject. These discussions were noted on a final (blank) sheet at the end of the interview schedule.

By these methods, it was hoped to achieve a combination of quantitative data suitable for ranking and comparing priorities (from closed questions and Likert-scale responses) along with a good qualitative feel for the views of the subject (through open questions and final general discussion).

For comparative purposes, an adapted version of the schedule was used as a questionnaire given to groups of senior executive nurses. These groups were mixed with regard to their NHS trust employer. Prior to being given the questionnaire, the standard introduction was read out, following which subjects completed the closed and quantitative elements individually. Open questions and discussion were then conducted in the group setting.

The variation between method for chief executives and senior trust nurses constitutes a limitation in the comparative validity of the results. In particular, the 1:1 interview with chief executives which precluded any group influence on reported views makes the qualitative information from chief executives more secure. Because of this, comparative analysis of the two groups is restricted to the quantitative elements of the schedules, all of which involved individual responses without any possible group effects.
Statistical analysis

For each subject group, Likert scale means and standard deviations were calculated for each statement (small standard deviations occur when responses are fairly homogeneous across a sample). Comparison of means for the two subject groups (chief executives and senior executive nurses) was conducted using a t-test for independent samples. As a significant difference between means in either direction was of interest, a two-tailed test was employed. In this test the null hypothesis was that there is no significant difference between means. From the t-value, the probability (P) of the null hypothesis was calculated. As is conventional, when \( P > 0.05 \) there was considered to be insufficient evidence to reject the null hypothesis. Conversely, if \( P < 0.05 \) the difference in means was taken to represent a significant difference between the views of the two sample groups. These statistics were computed using SPSS/PC+ V2.0 software [Statistical Package for Social Sciences (SPSS) 1988].

For brevity, only statements that elicited a strongly positive response (i.e. a mean Likert score > 4) or for which there was a significant difference between chief executive and senior executive nurses' views are reported here. Readers interested in minority views are advised to consult the extensive data reported by Walters & Macleod-Clark (1993a, b). Although the meaning of each statement is clearly evident, readers requiring guidance on the technical significance or other aspects of the statements are directed to Humphreys & Davis (1995) and Walters & Macleod-Clark (1993a, b).

Limitation

A final limitation of the method relates to the sample. A t-test assumes that the sample is representative of the total population of subjects from which it is drawn. In this study the population must technically be considered to be the chief executives within the region, rather than across the country, as regional policy towards education, and local circumstances, may have constituted a formative influence on the subjects' views. Although for these reasons the validity of the results cannot be assumed across other regions, it seems likely, bearing in mind the general nature of the views reported, that they are not in fact region specific. In any event this does not constitute an issue when using the data as the research base for a regional development such as QUACE.

RESULTS

Chief executives

Of the 26 statements put to chief executives regarding education, 11 elicited mean responses greater than 4 (maximum = 5; Table 1). These 11 constituted a 'mixed-bag' of attributes which chief executives considered to be important features of education. The meaning and significance of these priorities could be derived from the data elucidated by the qualitative information drawn from open questions and more general discussion. For the moment it is sufficient to note that the relationship between NHS trusts and colleges appeared to take high priority in the minds of chief executives. Arguably, no less than five out of the 11 high priority statements were concerned with aspects of relationship. These included partnership in evaluation; willingness to negotiate; understanding service needs; attitude to trusts; and nurses involved in education.

Along with and underpinning these quantitative findings, the study revealed a number of consensus views that emerged from open questions and the general discussion encouraged later in the interview. Only in the context of these qualitative findings can the quantitative data be properly understood. Although the views of chief executives differed with regard to many specifics, five broad areas of consensus emerged from the present study.

These related to:

1. the current situation of NHS trusts;
2. the role and desirable characteristics of education;
3. perceived problems with the principles of WP10;
4. approaches to the evaluation of education;
5. nurse education as higher education (although these views regarding Project 2000 were less systematically achieved).

In reporting these views, quotations from chief executives will be used to describe general features of their thinking that were widely held by the subjects interviewed. These consensus areas are largely attitudinal, reflecting an ideological position rather than constituting agreement on specific and detailed features of local provision.

Table 1 Characteristics of education prioritized by NHS trust chief executives: mean score > 4 arranged in rank order (n = 15)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Characteristic</th>
<th>Mean score</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Partnership in evaluation</td>
<td>4.93</td>
<td>0.267</td>
</tr>
<tr>
<td>2</td>
<td>Willingness to negotiate</td>
<td>4.92</td>
<td>0.258</td>
</tr>
<tr>
<td>3</td>
<td>Theory - practice link</td>
<td>4.60</td>
<td>0.737</td>
</tr>
<tr>
<td>4</td>
<td>Understanding needs of service</td>
<td>4.53</td>
<td>0.915</td>
</tr>
<tr>
<td>5</td>
<td>Attitude to trust</td>
<td>4.53</td>
<td>0.640</td>
</tr>
<tr>
<td>6</td>
<td>Calibre of preregistration students</td>
<td>4.36</td>
<td>0.477</td>
</tr>
<tr>
<td>7</td>
<td>Match with future needs</td>
<td>4.33</td>
<td>1.155</td>
</tr>
<tr>
<td>8</td>
<td>Pass rates</td>
<td>4.33</td>
<td>0.724</td>
</tr>
<tr>
<td>9</td>
<td>Cost</td>
<td>4.27</td>
<td>0.750</td>
</tr>
<tr>
<td>10</td>
<td>Nurses involved in education</td>
<td>4.27</td>
<td>0.914</td>
</tr>
<tr>
<td>11</td>
<td>Reputation of college</td>
<td>4.08</td>
<td>0.641</td>
</tr>
</tbody>
</table>
The situation for NHS trusts

Perhaps not surprisingly, in open questions and discussion all subjects raised issues relating to NHS reorganization, change management and the implications of these for the education and training of health care professionals. Chief executives, for example, identified a new ‘competitive environment’ in which corporate NHS trusts operate as businesses. A key element of this ‘new world’ is the ‘changing role of the qualified nurse’.

Three broad and related themes emerged in this respect, the first concerning ‘more fluid role boundaries’ expressed variously in terms such as ‘flexibility’, ‘adaptable workforce’, ‘a different type of practitioner’ and ‘skill mix changes’. Second, concerning ‘professionals who are also managers’: this point took a variety of emphases, including general ‘management of change’ through ‘nurses taking a proactive management role’ to ‘ward sisters as managers’ of both ‘the ward and its resources’. Third, concerning the contrast between these new roles and the ‘traditional role’.

These themes emerged with strong consensus across both acute and community trusts. Although the question of service quality was not specifically investigated, it was repeatedly raised by subjects and appeared to be a major preoccupation.

The role and characteristics of education

Two themes emerged regarding the role of education, one concerning workforce supply and the other relating to the sort of qualitative changes in the role of nurses specified above.

Pre-registration nurse education was generally seen in terms of workforce supply, generating a pool of qualified nurses from which NHS trusts can recruit professional staff. As such it was described as appropriately linked to ‘manpower plans’ (sic) with the size and nature of education contracts being determined ‘to fit’ such plans. Three subjects made the point, however, that their workforce planning analyses were not yet sufficiently secure to provide the sole basis for determining pre-service education activity.

Twelve subjects raised the issue of a role for education with regard to professional role change. This point was related both to pre-registration education, which should for example ‘prepare nurses who understand the wider context of the business and how services are managed and provided’, and to post-registration provision which should, among other things, ‘reorientate staff in the context of planned change’ and ‘help with skill mix changes’. This qualitative role for education in relation to change was also frequently extended into a wider organizational context. In general terms, there was a perceived need to ‘match education outcomes to health outcomes’ and ‘help with the management of change’. In some cases an explicit link was made to more political issues, such as the need to overcome traditional nursing hierarchies, which will be discussed further below.

We are now in a position to understand better the quantitative data reported in Table 1. In order to fulfil the roles identified for education, trust chief executives appear to take the view that a close collaborative partnership with education providers is desirable.

This concept of partnership tended to be clearly specified by subjects as a relationship between trust client and education provider, thus: ‘It is important that the college works as partner with an interest in the [health care] providers’ business — working together on a pragmatic basis.’ In this way the ‘college works with trusts and shares ideas about the type of flexible practitioner who will be required in the future and how they will be produced.’ These last two quotes, typical of chief executives’ views, were echoed by senior executive nurses who, for example, envisaged colleges ‘working in partnership to identify needs rather than just putting on courses and expecting us to attend.’

From these ideas, along with the high prioritization of relationship features shown in the quantitative data, a view emerged of an ideal in which a close business relationship between trusts as clients and ‘colleges’ was seen as potentially part of the solution to the change issues currently facing NHS trusts.

This ideal or desired state of affairs would, however, be dependent in the last analysis on the ‘attitude’ of colleges (Table 1). In this respect, chief executives were looking for a ‘wholehearted commitment from the teachers’ and an ‘acknowledgement of the new world’ by colleges who should show ‘no preciousness’ and be ‘outward looking to the customer’ (i.e. the trust).

Perceived problems with education

A third area of consensus related to the relationship of the ideal features of education to reality. In this respect, the views of chief executives were characterized by a degree of suspicion and cynicism regarding the current educational dispensation.

For reasons of confidentiality, trust staff’s views and remarks regarding specific aspects of college services will not be reported. In the event, these opinions were of less general interest than their strong and largely consistent views in relation to the system of education in general, and aspects of WP10 in particular.

Ten chief executives were inclined to be critical of the principles and implications of WP10. For some the separation of education funding out of the main service contracts was problematic.

Various different arguments were given for this view, exemplified by the following quotes.

Because it is a separate market WP10 doesn’t fit in with the trust planning cycle — clinical placements for example could be part
of our business plan but cannot be as it is not in sync, so it adds to confusion.

Regions are always going to be out-of-touch with reality on the ground.

WP10 at region lacks the immediacy of local control — region will always be remote from the action.

Education should be part of the real world — not developing a huge self-perpetuating industry.

These quotes convey various perceptions of mismatch between the principles of WP10 and the 'real-world' priorities of NHS trusts. From chief executives a perception of mismatch emerged of education with its own set of agendas rather than having a 'wholehearted commitment' to NHS trust needs: a situation created or exacerbated by the distance of the WP10 control and contracting process from the trusts. For some, both the origin and character of WP10 exemplified deeper issues of conflict between 'traditional' professional territories and the new reality of corporate health service providers in competitive markets. On this issue, vehement comments were sometimes made by chief executives.

Nurses may think that WP10 is cozy — that it may protect them by keeping their professional territorial rights — but it actually prevents them [education] playing on the team.

Working paper 10 is the result of professional tribalism and lack of trust — it is about vested professional interest.

These and other similar comments revealed a level of irritation amongst some trust chief executives expressed by one in terms of a 'political orientation' institutionalized within a system of education funding that can 'protect' traditional attitudes or at least hinder the changes they are expected to achieve. In other words, the ideal of wholehearted commitment by colleges striving, through pre- and post-registration education and training, to assist with a high rate of change in service provider organizations, was considered to be impeded by the system and control of funding enshrined in WP10. Four chief executives explicitly related this type of argument to the development within their trust of (post-registration) training units funded out of their service contract monies.

The evaluation of education

Because this work constituted the first phase of a research and development project with the aim of involving NHS trusts in education contracting processes, questions on the evaluation of education were included. At that time the RHAs' view on the quality of service delivered by education providers was based largely on information received from the colleges rather than the trusts. With a view to achieving more objective analyses the views of the trusts were sought.

Models of evaluation

Three models of evaluation were discussed:

1. the then current model based largely on colleges' perception of their own quality;
2. evaluation based entirely on individual trust's analyses and reporting on education quality;
3. based on a 'partnership in evaluation' in which some sort of interactive process between trust and college informed or developed a trust view.

All chief executives expressed a strong preference for the third model, with one or both of two reasons being given. First, while in principle they did not feel that commissioning decisions should be based only on an education provider's own view of its quality, they also did not feel they had the resources that would be necessary to achieve a secure view independent of college involvement (they recognized that colleges already put considerable effort into evaluation/quality processes). Essentially they envisaged that secure views on quality could be achieved through a process of evaluation in which the effort of the college could be harnessed to scrutinize the extent to which trust objectives for education were met. Second, this interactive process was also considered as potentially a constructive process in which a creative dialogue could be formally linked into the commissioning procedures.

This preference with regard to evaluation was picked up in the quantitative data, with 'partnership in evaluation' producing a very high mean (4.93). However, the chief executives were explicit about the business nature of such a partnership in evaluation. They saw it as an opportunity to focus evaluation on their own agendas for education but were not inclined to put much resource into the process. They envisaged the trust 'lead officer' on educational evaluation being a senior person, some preferring professional nurses (six identifying directors of nursing or comparable positions, two identifying the chief nurse) with others preferring to identify the director of human resources (three) or the education and training director (one).

This 'lead officer's' role was envisaged as taking up a very limited amount of time with their major priorities being elsewhere. The lead officer's maximum time commitment on education was expressed variously as 'a very small fraction'; '1 day per month' (two); '10%' (two); '4 days per month'; '6 days per year' and other similar durations. Therefore, although varying, the chief executives were consistent in the view that the time spent contributing to the educational evaluation within the trusts should be small.

Nurse education as higher education

Although not specifically investigated, most subjects volunteered views relating to Project 2000 and the location
of nurse education in higher education. As this subject did not constitute a systematic part of the study, the evidence achieved must be considered anecdotal. However, because some comments can be seen to be linked with the consensus views reported above, they are reported.

Of the seven chief executives who commented in this area, one favoured the incorporation of nurse education into higher education on the grounds that trusts needed 'confident nurses with the ability to challenge'. The others, however, were less convinced, although the comments can be characterized not so much by opposition as doubt, based variously on concerns of elitism (e.g. 'I least like the caps and gowns separation'); distraction from priorities (e.g. 'they may have gone too far to the academic — anatomy and physiology — but we do not need academics, we need people who can deliver a service'), and irrelevance (e.g. 'I couldn't care less about university links, I care about the clinical competence of the teachers').

These types of comment, along with the views on education reported above, suggest that a more systematic study of the perceived relationship between Project 2000 and general NHS reorganization may be worthwhile.

**Differences between the views of chief executives and senior executive nurses**

In the quantitative part of the survey, mean responses of senior executive nurses were broadly consistent with those of chief executives for most of the statements. All but one of the chief executives' priorities (mean score >4) were also scored highly (>4) by executive nurses. Only 'reputation of college' failed to rate this highly (mean = 3.93). However, for six characteristics in total, executive nurses' mean scores differed significantly from those of chief executives: these are shown in Table 2. To some extent these differences appeared to reflect their greater preoccupation with more detailed aspects of the processes of education [teacher : student ratio, (b); teachers who are both qualified nurses and qualified teachers, (c) and (d); educational research at the college (e); and the enthusiasm of students (f)]. Nevertheless, in so far as these features imply a particular model of nurse education, they are significant to colleges and will be discussed later.

Finally it is interesting to note that cost of education was considered less important by chief executives than by senior executive nurses. This statistically significant difference cannot be securely explained from the qualitative information achieved by the present study. However, it is of interest in this respect to note that subjects appeared to vary in their interpretation of the statement, some taking it as general (i.e. in principle, cost is important) and others as specific (i.e. since our trust is not paying for it, it does not matter to us). The latter position was more commonly adopted by chief executives.

**DISCUSSION**

Wellington (1993), after reviewing a number of surveys of employer perceptions of vocational education, reported their statements to contain a conceptual mixture of desirable 'attributes, qualities, dispositions, attitudes...', etc. This finding is corroborated by the work of Walters & Macleod-Clark (1993a, b) and the present study, where top ranking characteristics of education range from general attributes (such as reputation) through attitudinal dispositions (willingness to negotiate, attitude to trust) to specific qualitative features of curriculum (relating, for

**Table 2** Differences of emphasis in the views of NHS trust chief executives and senior executive nurses with regard to certain characteristics of education considered important: significant differences ($P<0.05$) between mean scores

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean scores (±SD)</th>
<th>t-value</th>
<th>Degrees of freedom</th>
<th>Significance ($P$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Cost</td>
<td>4.27 (0.790)</td>
<td>-2.53</td>
<td>27</td>
<td>0.018</td>
</tr>
<tr>
<td></td>
<td>4.85 (0.363)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Teacher–student ratio</td>
<td>3.13 (1.125)</td>
<td>-2.92</td>
<td>27</td>
<td>0.007</td>
</tr>
<tr>
<td></td>
<td>4.14 (0.663)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Teachers who are nurses</td>
<td>2.71 (0.914)</td>
<td>-2.67</td>
<td>26</td>
<td>0.013</td>
</tr>
<tr>
<td></td>
<td>3.64 (0.929)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Teachers qualified as teachers</td>
<td>3.36 (1.216)</td>
<td>-2.20</td>
<td>26</td>
<td>0.037</td>
</tr>
<tr>
<td></td>
<td>4.21 (0.806)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) Educational research at the college</td>
<td>3.06 (1.033)</td>
<td>-3.33</td>
<td>27</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td>4.21 (0.802)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f) Enthusiasm of students</td>
<td>3.80 (0.062)</td>
<td>-2.63</td>
<td>27</td>
<td>0.014</td>
</tr>
<tr>
<td></td>
<td>4.50 (0.519)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ref: NHS Trust.195.

example, to match, evaluation and theory-practice link) among other things (Table 1).

Although disparate, the nature of these high priorities, however, when elucidated with responses to more open questioning, revealed strongly held and coherent views on the role of education and, from this, logically related stances regarding evaluation and the structure of the WP10 market. Therefore the analysis of superficially disparate priorities, widely held, revealed not incoherence but in fact a set of related ideas and values of the sort commonly referred to in curriculum theory as an educational ideology.

**Ideological stance**

In ideological terms, the views of chief executives regarding education can be described as 'instrumental' (Scrimshaw 1983). In this ideological stance, the role and value of education is specified in terms of utility: the quality of education therefore being judged with regard to its impact on trusts’ ability to deliver health services.

The exact nature of the instrumental ideology held by chief executives is revealed as deriving from their current position as corporate organizations in a volatile and competitive environment, i.e. they can be seen to be preoccupied with their own corporate needs at a time of change. Because of this, chief executives were explicit about a role for education in helping with organizational development and the changes implied by the new markets in which they operate. Thus they identified qualitative features of the new nurse rather than simply demanding a numerically sufficient workforce supply. In this context, as the new trusts feel the need to specify the nature of the new nurse, the flexibility and responsiveness of the education provider becomes critical.

This form of instrumentalism, where explicit links are made between education and the development of independent organizations operating in quasi-market conditions, has been referred to as 'corporate instrumentalism' (Humphreys 1994). It carries with it the logical consequence that employers would wish to control education spending to their own ends. However, as this is such a remote possibility in most industries employing higher education qualified staff, more common forms of instrumentalism focus on more general features of national economic development and performance, and the sufficiency of the workforce pool, with the nature of the professional not being linked by employers to organizational change.

The concept of corporate instrumentalism was originally derived from a literature review combined with a theoretical analysis relating to WP10 funding policy and the emergence of the new corporate NHS trusts. In terms of chief executives’ views on the role of education, the data reported here provide some empirical evidence in support of the concept. More interestingly, however, it reveals the mechanisms of client-provider partnership through which employers envisage corporate priorities can be addressed. Moreover, it is clear that these mechanisms are considered necessarily to be located in the context of a market for education in which contracting decisions are devolved to employers. In so far as it does not clearly do this, WP10 is considered problematic by chief executives.

**Quasi-market theory**

In developing a theory of quasi-markets, Bartlett & Le Grand (1993) have identified various criteria of success against which such markets can be measured. Amongst these is the criterion of ‘responsiveness’. By replacing old-style bureaucracies with market mechanisms as the main means of co-ordinating services, it is supposed that the responsiveness of provider organizations to client needs would be improved. Critics of bureaucracies regarded bureaucrats and professionals as preoccupied as much with their own interests as those of their clients (Propper 1993). In fact, this position may be more ideologically driven than based on systematic empirical evidence but, in any event, it has been a factor in the development of various quasi-markets since 1988.

The present study reveals responsiveness to be an important attribute of education provision as viewed by trust chief executives. As they are themselves operating as providers in a quasi-market (for health services) it is perhaps not surprising to find a broadly consistent view emerging. This view is characterized on the one hand by a model of relationship (provider/client partnership) in which responsiveness could (they suppose) be achieved, and on the other by doubts about the ability of the WP10 quasi-market structure to facilitate such responsiveness.

In the context of quasi-market theory, the concerns over market structure are perhaps more fundamentally problematic than any perceived reluctance of education providers to be responsive. This is because, as we have seen above, it can be argued that quasi-market arrangements are (in part) intended to remedy any reluctance amongst providers to make a response. In this particular case, the WP10 quasi-market arrangement should [if successful by Bartlett & Le Grand’s (1993) criterion] be capable of creating the circumstances in which providers of education must be responsive. Clearly chief executives doubt that WP10 can achieve this.

The analysis of chief executives as to why the WP10 market cannot consistently address their needs relates to the demand side of the market. As we have observed in the introduction, in many quasi-markets (WP10 included) purchasing is not conducted by the direct recipient of the service purchased. WP10 purchasing is controlled by regions rather than the trusts themselves and it is this that constitutes the basis of chief executives’ doubts about the system. As we have seen regions are considered inevitably
'remote from the action' and 'out-of-touch', with the result that education is not perceived as 'part of the real world'.

In fact there are other features of the WP10 quasi-market that could reduce its ability to generate responsiveness in education providers. Among these and relevant to the present report is the issue of information. In theory an effective market (i.e. one that generates responsiveness in providers, among other things) is characterized by a good knowledge of the quality of service (or product) on the demand (purchasing) side. Thus the evaluation of quality in terms set out by the purchaser and/or recipient is important, as indeed are the concepts of quality held on the demand side. This idea is implicit in the desire (reported above) of NHS trust chief executives to inject rigour into the evaluation of education services by involvement (albeit undemanding in resource terms) in the evaluation process. Subsequent to this research, such an involvement has in fact been designed into the QUACE system in such a way as to require NHS trusts to be explicit about their views on what constitutes quality, while also enabling them to feed their views via consortia to the regional purchaser (Humphreys et al. 1994).

Quality of educational services

Measuring the quality of educational services is, however, always problematic, not least due to difficulties obtaining evidence on the performance of the trained nurse output (Fitzpatrick et al. 1994). As the quality of this 'product' is difficult to measure, there is a tendency for quality to be judged on the basis of input specifications (e.g. student : staff ratio). There is, however, evidence to suggest that when used in a quasi-market situation such input specifications can suppress innovation in the service. Work by Schlesinger et al. (1986), for example, indicated that contracting led to a lack of innovation (in care delivery) in the USA, as contracts were less likely to be given to providers who, by developing new methods of service delivery, fell foul of orthodox process-based measures of quality.

In this context, the significant differences between the views of chief executives and senior executive nurses reported in Table 2 are particularly interesting. Of the six characteristics in which the mean score was significantly different, five related to process measures (teacher : student ratio; teachers who are nurses; teachers qualified as teachers; educational research at the college; enthusiasm of students) and in all cases, chief executives were less inclined to rate them highly.

Although no doubt such measures could be argued to relate to quality in orthodox education services, innovative approaches might not measure up positively in these terms. Consider, for example, the teacher : student ratio of any sort of 'resource-based' learning (such as distance learning) where the available teacher resource is reduced but where this could arguably (other circumstances being appropriate) correspond to equal or improved quality, if sophisticated paper, information technology and other resources are brought to bear. If, as is indicated above, senior executive nurses are more likely to be involved in education evaluation than chief executives, then evidence from Table 2 can be taken to provide some indirect corroboration for Schlesinger et al.'s (1986) idea that quasi-markets can suppress innovation. In any event a possible mechanism for such an effect has been identified for nurse education.

Overall, chief executives' doubts on the ability of the WP10 quasi-market structure to generate responsive educational services which meet their instrumental requirements, derive ultimately from the fact that it is a separate market functionally distinct from the large health services market in which they are providers. Controlled by different people (regions), it has the potential of remaining immune to the imperatives of health service reform with which trusts are struggling.

Such asymmetries and tensions between the two markets can also be analysed in terms of the professional status of nursing. Among the wide range of characteristics claimed for a profession (see Siegrist 1994 for a recent review), the idea that professions control and regulate their own practice constitutes a recurring theme. Various aspects of recent NHS reforms, however, can be interpreted as eroding this status and therefore contributing to a process of deprofessionalization. Haug (1973) defined deprofessionalization as 'a loss to professional occupations of their unique abilities, particularly their monopoly over knowledge... and expectations of work autonomy', and Derber (1982) has argued that the subordination of professionals to corporations necessarily implies a loss of control that can relate both to the work itself and the values, goals and social purposes to which the work is directed.

Although education and its control within the professional cadre is widely considered as an important mechanism through which professions maintain their character (e.g. Houle 1980), we have seen that the corporate instrumentalism manifest in chief executives' responses leads them to claim the legitimacy of a direct influence on education and training that cuts across conventional professional territory. Not only are they inclined to define the skill mix of the practitioners they require, but they also stress value-laden issues such as an understanding by practitioners of the new business environment. In so far as they actively seek to bring about such changes the chief executives will indeed constitute a force for deprofessionalization, not only through their position as corporate employers but also as the current empirical study suggests, through the new education market.

However, it is also clear from the present work that the WP10 market itself contains tensions that may neutralize any such effects. With chief executives doubtful about the
current function of regions in the WP10 market, it is perhaps not surprising that they identify clear limits on their own WP10 lead officer's involvement. This can be seen as one manifestation of a reluctance to participate in consortia, which has also been reported elsewhere (Humphreys & Davis 1995). If doubts about the quasi-market structure and the regional role in particular lead trust chief executives not to take the opportunity to exert influence through consortia and quality systems such as QUACE, then education purchasing may indeed remain immune from some of the realities of health service reform they that could powerfully represent. In this sense chief executives' doubts could be self-fulfilling.

A second source of ambiguity relates to the significant differences reported above between chief executives and senior nurse views with regard to the importance they attach to the features of the education process (as opposed to education output). Here the market mechanism identified as capable of suppressing innovation in health care education carries the additional potential of effectively (although not necessarily intentionally) maintaining the status quo and thereby impeding in one small way the process of deprofessionalization implied by the chief executive's views.

The universities

A final tension in the WP10 market relates to the question of universities as increasingly prevalent on the supply side. The shift of nurse education into higher education carries with it the implication of enhanced professional status. When such a move is not the result of national policy the anticipated, and for some contentious, professionalization effect on nursing can lead to delay and controversy, as Parkes (1986) has shown in the Australian context. In contrast the Project 2000 reforms have been implemented relatively quickly as the result of national policy.

Interestingly in terms of the professional status of nurses, the distinct but contiguous policy developments of Project 2000 and NHS reform constitute opposing influences: the former tending to professionalize and the latter (due to the introduction of corporate employers and consequent managerial imperatives) tending to deprofessionalize. (Humphreys 1995). This policy ambiguity can be seen in the WP10 market, where a professionalizing supply side (universities) now seeks to serve a deprofessionalizing demand side (NHS trusts). That chief executives are aware of this tension is suggested in the present work by the fact that a number of them have doubts about the value of Project 2000.

Furthermore, in addition to this supply side-effect, even the demand side of the WP10 market is considered suspect by some chief executives, who regard regional control of education commissioning tantamount to professional control, hence the comments on WP10 being the result of 'professional tribalism' and maintaining 'professional territorial rights'.

CONCLUSION

Overall, then, the WP10 quasi-market can be seen to be riven with tensions, ambiguities and contradictions, not only between the supply and demand sides of the market but even within the demand side itself. In these circumstances it remains to be seen whether the WP10 quasi-market in fact facilitates or impedes health care reform. The paradoxical prospect emerges in which an ideologically driven move to market structures has, by creating separate markets for closely linked activities such as health care and health care education, gone beyond the point where a strategically harmonized approach to health service reform can emerge.

Can two markets generate a single strategically harmonized health service reform? The QUACE system attempts to bring this about by devolving considerable influence to trusts. But it is too early yet to provide a secure assessment of whether such a multimarket situation does in fact constitute sound policy.

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References


The impact of the EN conversion programme on the NHS nursing workforce

Jane Hemsley-Brown and John Humphreys

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Abstract

States that the number of enrolled nurse conversions completed during the last ten years has had a significant impact on the number of registered nurses (RNs) available for employment in the National Health Service (NHS). The contribution made by the enrolled nurse conversion programme to the NHS workforce may have delayed the impact of the “demographic time bomb” on nursing recruitment. The imminent winding down of the conversion programme, combined with a fall in entries to pre-registration (initial) training, could exacerbate the chronic shortage of nurses in the next decade.

National Health Service workforce statistics[1], show that there was a steady rise in the number of first-level nurses employed in the NHS workforce between 1987 and 1992. This rise coincides with the conversion of over 30,000 enrolled nurses (ENs) to RN status. The number of RNs, working in the NHS increased by 23 per cent from 194,590 in 1987 to 239,660 in 1992 – over 45,000 additional RNs. The number of qualified nurses (including both second- and first-level nurses) increased by 10 per cent, over five years from 279,600 in 1987 to 306,410 by 1992. In the five-year period up to 1992, the NHS employed over 26,000 extra qualified nurses. Between 1992 and 1994, however, there was a -3 per cent decline in the number of RNs, and a -6 per cent decline in the number of qualified nurses employed in the NHS, representing a loss of over 17,000 qualified nurses, including some 6,000 RNs.

The proportion of second-level nurses has declined throughout the whole period (1987-1994), but the total number of qualified nursing staff employed in the NHS has increased, and the proportion of first-level nurses has also increased. In 1987 the NHS employed 85,020 second-level nurses (ENs), and by 1994, during a period when the conversion programme was gaining strength, this figure decreased to 56,080 – a loss of 28,940 enrolled nurses (see Figure 1). However, figures provided by the English National Board (ENB) show that between 1987 and 1994, an accumulated total of 31,142 ENs had achieved first-level status, and the NHS therefore could have expected to lose over 30,000 ENs (before losses due to “wastage” are taken into account). The decline in the number of ENs employed in the NHS therefore was lower than expected – especially because during the same period pupil nurse
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Figure 1 Number of first- and second-level nurses working in the NHS

![Graph showing number of first- and second-level nurses working in the NHS]

Key
- Registered nurses – total
- Enrolled nurses – total

Training was being phased out, and there were very few newly qualified ENs joining the workforce.

Between 1987 and 1994 the NHS employed over 38,000 extra registered nurses. There are no figures to indicate what proportion of RNs employed in the NHS are converted ENs. We may assume, however, that converted ENs have contributed towards the total number of first-level nurses working in the NHS during this period. If all 31,142 ENs who had converted by 1994 were included in the figures, then more than three-quarters of the increase in RNs could be accounted for by converted ENs. The remaining 7,000 additional RNs employed between 1987 and 1994 would be accounted for by new registrations, increased retention and return-to-work factors, combined with losses due to retirement and wastage. The factors are interrelated and complex, but the figures suggest that the conversion programme has encouraged ENs back to the profession and has increased retention by reducing the number of nurses who would otherwise have left nursing. The shortage of manpower was eased in some clinical areas which are traditionally difficult to staff, because ENs needed to be in employment with a health authority in order to secure a (seconded) training place[2].

It is acknowledged, however, that some converted ENs are working in the private sector, or working for agencies, and would not be included in the NHS figures. Nevertheless, the enrolled nurse conversion programme has made a marked contribution to the total number of registered nurses working in the NHS. Figures provided by the ENB show that during the period 1987-1995, 32,868 enrolled nurses completed conversion to achieve first-level nurse status (Figure 2). The statistics imply that a peak in the number of completions each year was reached in 1993, when 6,733 ENs achieved registered status, and confirm that the combined programmes have the capacity to provide training opportunities for over 6,000 ENs each year. In 1993-1994 a decline began. This decline coincides with a decline in the overall number of first-level nurses, and qualified nurses employed in the NHS, and a decline in recruitment on preregistration nurse training (traditional and Project 2000 trainees).

The NHS relies for the future nursing workforce on the number of preregistration trainees undergoing initial training. During the period 1987-1992, recruitment of new preregistration trainees remained stable, at between 15,000 and 16,000, suggesting that health authority manpower planners controlled the numbers entering training during this period. English National Board statistics show that in 1993/4 a reduction to 12,460 was recorded and a further decline in recruitments followed in 1994/5, when only 10,844 entered preregistration training on traditional and Project 2000 programmes (Figure 3). (Pupil nurse training was phased out during the period from 4,390 to nil by 1992.)

Between 1987 and 1992, when the number of recruits entering preregistration training remained stable (and latterly declined), the total number of registered nurses employed in the NHS was rising. United Kingdom Central Council (UKCC) statistics show a rise in registrations during the same period, with a slight decline in 1994[3]. Trusts are responsible for recommending nurse training numbers[4] and workforce planning is based on an analysis of current and predicted manpower requirements. There are two possible

Figure 2 Total number of conversions each year

![Graph showing total number of conversions each year]

Note: * = 1995 figures incomplete

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16,860
15,920
12,460

18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0

Year

January
February
March
April
May
June
July
August
September
October
November
December

16,940
16,722
16,720
16,450
16,860
15,920
12,460
10,844

3 Number of preregistration entries including Project 2000

Preegistration trainees

1991/92
1992/93
1993/94
1994/95

A recruitment crisis, even though the demographic time bomb was expected to have full impact in the mid-1990s, when entries to (initial) pre-registration training show a decline. (There were 3,559 16-19-year-olds in 1985, but only 2,615 by 1995 — representing a 27 per cent fall over ten years[7].)

The statistics show that the conversion course programme compensated for the loss of the pupil nurse throughout the period 1987-1990, and the funding which had historically been set aside for pupil nurse training was diverted towards conversion course programmes[2]. Statistics provided by the Department of Health combined with ENB figures confirm that during the period 1987-1992, pupil nurse training and conversions added together numbered between 5,000 and 6,000 trainees each year. During 1986/7 there were more pupils, but by 1991/92, 6,691 trainees were on conversion courses, and pupil nursing had been phased out (Figure 4). These 5,000-6,000 extra newly registered nurses have provided a significant boost to the health service workforce over the last decade.

The real impact of the conversion course programme on the nursing profession over the last ten years is set to become very clear by the end of the century. The EN conversion programme should have achieved its aims by the year 2000. Evidence is provided by the National Audit Office[8], claiming that figures for the number of enrolled nurses eligible and wanting to convert (as at November 1991, in ten regions) stood at 22,800. The number of planned places on conversion courses between 1992 and 2000 was 21,500.

A survey of enrolled nurses by the South Thames Regional Health Authority[2] further claimed that it will only take five years to

Figure 4 Comparison of pupil nurse entries with conversion entries

Pupil nurses entering training
Total number of EN conversion entries
convert all the ENs in the region who want to convert. The decline of the conversion course programme coincides with a decline in the number of registered nurses in the NHS, and with a fall in the number of entries to preregistration training.

Finally, key factors that affect the number of qualified nurses available for employment in the NHS are recruitment, retention and return. Traditional nurse training produced high wastage rates, and a high percentage of qualified nurses left the profession. Reid[9] claimed that in 1985 training wastage was 35 per cent for registered nurses, and claimed that there were not enough jobs in the NHS for newly qualified nurses at the end of their training. The “slack” in the system has previously allowed the NHS the flexibility to implement strategies such as “back to nursing” schemes when the supply and demand balance changed for the worse, to attract some of these nurses back to the profession. However, one of the few drawbacks of reducing training wastage and increasing retention (achieved partly by shifting nurse training to higher education, and replacing the apprenticeship model), is that there are fewer nurses out of the profession to call on when shortages occur.

A decline in the total number of qualified nurses working in the NHS began in 1993, after a steady rise throughout the five-year period 1987-1992. The winding down of the conversion programme, with a loss of up to 5,000-6,000 newly registered nurses each year, combined with a dramatic fall in recruitments by up to 5,000 trainees each year, may signal the beginning of the long-awaited crisis facing the nursing profession, unless the drive to recruit more nurses is given priority. The cycle of wastage, shortages, low morale and falling recruitments could continue unless strategies are reviewed now to retain the valuable nursing workforce already weary through pressure of extra work. Unless all available manpower planning tactics are combined to secure a nursing workforce for the future, the demographic time bomb may explode after all, and those nurses who remain will be expected to work even harder and for longer hours, to meet the needs of their patients.

References


Further reading

Education commissioning by consortia: some theoretical and practical issues relating to qualitative aspects of British nurse education

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INTRODUCTION

The initiation in 1991 of reform in the British National Health Service (NHS) triggered a period of intense change associated with the development of a new 'internal market' for health services. Among the main features of change was the establishment of NHS trusts as major new providers on the supply side, and the development of district health authorities (DHAs) into purchasers of services on behalf of local populations. Additionally, new general practitioner (GP) Fundholders were given control of funds to purchase hospital services for their patients, while more generally DHAs and family health service authorities (FHSAs) were encouraged to work more closely together to achieve a 'new balance' between hospital, community and primary care services (Department of Health 1990).

During the early years of these reforms, elements of the original NHS management structure were left intact so as to provide some stability in an otherwise radically changing dispensation. In particular, the 14 regional health authorities (RHAs) in England were left in place and indeed took on new functions in relation to workforce supply and...
the funding of education and training for staff groups other than doctors and dentists (i.e., non-medical education and training or NMET).

**Review**

In May 1993, the Department of Health (England) set up a Functions and Manpower Review to examine progress relating to the implementation of the reforms and identify areas for improvement. In the light of this review, the secretary of state for health determined, among other things, to streamline the management structure. Continuing a process of decentralization and devolution, it was decided to abolish the regional health authorities and replace them with eight regional offices of a reorganized NHS Management Executive (subsequently renamed the NHS Executive) (Department of Health 1994).

In response to the anticipated abolition of RHAs, work commenced on a new framework for planning and commissioning NMET, the results of which were published in March 1995 (Jarrold 1995 — subsequently referred to as EL9527). As a principle element this new framework includes consortia of NHS trusts, purchasing authorities, GPs and social services authorities. Consortium functions include: collating workforce plans, estimating demand for newly qualified staff and, increasingly, 'commissioning education direct from education providers'. With regard to non-medical education and training commissioning, it is envisaged that consortia will need to be 'operational budget holders'. A feature which will enable them to 'influence not only numbers, but also quality, admission policies and "fitness for purpose"'. It was expected that some consortia will begin to take devolved control of budget holding and contracting from April 1996.

This paper will examine the position and significance of consortia from both theoretical and practical standpoints. Firstly, the role of consortia will be analysed in terms of quasi-market theory, and, secondly, related practical issues of consortium functioning will be addressed largely on the basis of experience in the South Thames Regional Health Authority. The paper will concentrate on the training of nurses in England, the largest single professional workforce group.

**THE ORIGINS OF CONSORTIA**

Prior to the NHS and Community Care Act (1990), most non-medical education and training had been conducted 'in-house'. In particular, each district health authority (DHA) had contained within it facilities both for the delivery of health care and the training of nurses. Furthermore, the funding of training was via a complex and bureaucratic system involving national boards and other organizations (Humphreys 1993). Since DHA schools of nursing were by no means financially distinct organizations the real costs of education and training were essentially hidden within the overall DHA financial accounting systems (Humphreys 1994).

For various reasons this position had been problematic in the context of general NHS reform: most particularly in order for the new 'internal market' for health care to operate properly, there was a need to make a clear distinction between the financing of health care delivery and the financing of health care education. This separation was achieved through the publication in 1989 of the tenth working paper examining the implications of the original white paper 'Working for Patients' (Department of Health 1989a). Working Paper 10 (Department of Health 1989b) established the principle of direct funding of education and training through regional health authorities.

With the new NHS trusts split off from DHAs and education and training funding routed through regions, the position of district schools of nursing became increasingly anomalous. Effectively DHAs were providing regionally funded education services for those NHS trusts from which they were also purchasing health services. In the event concurrent educational reform ('Project 2000') which positioned nurse education as a higher education activity (UKCC 1986) suggested a solution. With strong links already developed, it became inevitable that many schools of nursing would incorporate into universities, thus freeing the DHAs to concentrate on their new health care purchasing function, crucial to the success or otherwise of general NHS reform.

By 1995 all regional health authorities had determined that schools should be integrated into institutions of higher education (largely universities). It has been argued that this synergistic effect of Project 2000 (UKCC 1986) and NHS reform constituted a radical change for NMET, not least as it established a new and distinct market in which the providers of education and training became increasingly located outside the NHS (Humphreys & Quinn 1994). Furthermore, this market rather than being planned ab initio was created through the combined effects of the two relatively unrelated policy processes; an interpretation which has recently been corroborated by John Rogers (deputy director of personnel, NHS Executive) who described the resulting dispensation as an 'accidental market' (Rogers 1995a).

Although the exact character of the eventual market could not be made explicit in 1989, Working Paper 10 did identify a need to specify the outcome of training more precisely and recognized that a 'greater use of contracts' and a 'greater degree of competition between training providers' could be beneficial in this respect. Moreover it made clear that 'direct regional funding does not necessarily imply that regions should commission training', and introduced the notion of consortia of employers as an 'ideal' location for the commissioning function.
Employer consortia

This original conception of consortia can be traced via Working Paper 10 back to the general philosophy enshrined within Working for Patients that operational responsibility should be devolved to the lowest possible level. However, in the case of nursing and various other staff groups, commissioning by individual directly managed (health care) units and (increasingly) NHS trusts was not thought appropriate, mainly due to the fact that the qualified professional output of a school would be numerically much greater than the workforce supply needs of any one employer. Because of this, the notion of employer consortia as commissioning agents was raised and mildly encouraged.

Since Working Paper 10 positioned regions as funders of NMET, the abolition of regional health authorities demanded further work on the planning and commissioning system. At that time the possibility of total devolution to employers was revisited (i.e. letting employers such as NHS trusts deal individually and directly with education and training providers). However, in the context of a priority need to maintain a sufficient supply of qualified workforce, total devolution was not considered a serious possibility on various grounds, including planning (i.e. national or at least regional labour market planning for training on the basis of local circumstances is problematic); training efficiency (unit costs would be likely to rise in a market of many small purchasers); and fairness (i.e. turnover and wastage of staff — and therefore the need to purchase training for replacement — being determined by features of the labour market rather than just the employment practices of individual employers) (Rogers 1995b).

With total devolution to employers ruled out, consortia became a favoured option. However, the old consortia of NHS providers suggested in Working Paper 10 was by then also considered inadequate. In the first place it was felt that, in addition to employers' representation, consortium membership should also include health care purchasing agencies (for their long term knowledge of health service purchasing intentions) and social services (in line with the increased community emphasis of the reformed NHS). Furthermore, NHS demand for nurses was no longer considered a reliable proxy for non-NHS demand; with an increasing number of nurses in the private sector, consortia could not be expected to effectively plan training without private and volunteer sector involvement (Rogers 1995a).

Expanded consortia

In the light of such considerations an expanded consortium concept with wider representation was adopted and subsequently made mandatory as a feature of NMET planning and commissioning. Despite the differences between the consortia suggested in WP10 and those required in EL(95)27, in policy terms the notion of commissioning consortia can arguably be seen as a consistent and developing concept in a system were a fundamental desire to devolve to local employers is moderated by the need for efficiency and long term workforce planning in a labour market which is not local.

In any event this development means that the commissioning consortia now being assembled and developed across the country constitute a universal and probably long term component of the education and training market.

A QUASI-MARKET ANALYSIS

In a conventional market a supply side provides goods or services to a demand side consisting of consumers making purchasing decisions. In the absence of a monopoly, the consumer wishing to purchase a particular service can make a choice as to which service provider to use. From the provider's point of view, consumer choice means that they must compete effectively with other providers in order to stay in the business. Typically the purchaser is also the direct user or recipient of the service.

By creating a purchaser-provider split between district health authorities as commissioners and NHS trusts as service providers, the NHS and Community Care Act has, as we have seen, replaced a 'bureaucratic' means of coordinating health services with a market. Although this market may correctly be identified as internal, that is to say largely located within the NHS, it does nevertheless involve contracting, elements of purchaser choice, and therefore competition. However, unlike conventional markets, the purchaser is not the direct user or recipient of the service. Instead districts are considered to purchase health services on behalf of their local community who at the point of access become consumers.

Since the purchasing decisions of consumers are central to conventional market theory, markets in which purchasing and consumption are distinct cannot be analysed in orthodox terms. Such arrangements have instead been referred to by Le Grand & Bartlett (1993) as ' quasi-markets'. These authors have developed a theoretical basis for quasi-market analysis and reviewed the extent of their current application in social policy areas. Until now, however, the arrangements for NMET have not been subjected to analysis in quasi-market terms.

Central elements

Table 1 compares the central elements in a hypothetical conventional market for services with the quasi-markets for health care and NMET. For the purposes of this analysis, the two demand-side components are referred to as 'purchaser' and 'recipient'. In the conventional market, these functions reside in a single 'purchaser-recipient'...
Supply side

Notes

In the conventional market the consumer is both purchaser and recipient of the services. In quasi-markets, however, these functions are largely or completely distinct. The non-medical education and training quasi-market can be seen to be complex on the demand side where student consumers receive education and training (Recipient B) while NHS trusts receive workforce supply and professional development services (Recipient A).

who essentially exchanges money for a desired service. In contrast, both quasi-markets show the characteristic feature of distinct purchasers and recipients. On the supply-side the conventional market typically has a privately owned (i.e. owned by individuals or shareholders) for-profit service provider. In contrast, the quasi-market service provider is in both cases a public (i.e. government owned) non-profit organization (NHS trusts in the health services quasi-market and universities in the NMET quasi-market).

In addition to showing the distinction between conventional and quasi-markets, Table 1 also indicates an important difference on the demand side between the standard quasi-market for health services and the more complex arrangement for NMET. Essentially for NMET, there are two recipients of education and training services. Firstly the NHS trust employer for whom education and training fulfils workforce supply and professional development functions (Recipient A) and secondly the student consumer for whom education and training provides the skills and qualifications necessary to practice (Recipient B).

It is important to note that positioning the employer as a direct (rather than only indirect) recipient of services could not be effectively argued in most other major education and training quasi-markets (for example the further education sector or that part of higher education funded through the national funding councils). In this respect the crucial features of NMET are: (a) the direct and close nature of the relationship between the education provider and the employer (excepting the smaller professional groups, NMET providers typically work very closely with a relatively small number of large local employers), and (b) the devolved rather than national nature of the purchasing function (Bailey & Humphreys 1994). In this latter respect, it is interesting to note that, as consortia take up a commissioning role, the market becomes even more a local phenomenon than before and so departs further from the national funding arrangements, typically found generally in further and higher education.

Overall therefore, the arrangements for non-medical education and training constitute a complex form of quasi-market with two distinct recipients on the demand side. In this respect the arrangement is novel and clearly different from the relatively simple quasi-markets both for health services and mainstream post-school education generally.

NURSE EDUCATION AND NHS REFORM

Table 1 shows health care and non-medical education and training to be clearly separate quasi-markets with separate funding; distinct demand-side components and supply-side organizations which are separated not just by their traditions and corporate individuality, but also by the fact that they fall under different British government departments. Furthermore, this pattern constitutes a radical departure from pre-reform arrangements in which the DHA supplied both health services and non-medical education and training (referred to above as the 'in-house' model).

These new arrangements raise important questions in relation to NHS reform and the extent to which a distinct education market can contribute to it. To appreciate the full significance of this question we must first rehearse the fundamental nature of NHS reform. The internal market for health services was developed primarily to address the fact that in the United Kingdom (UK) as in most developed countries the demand for health care exceeds supply --- a situation that led the NHS into acute financial difficulties in the 1980s (Ham 1992). The NHS and Community Care Act can therefore be seen as an attempt to increase the efficiency of the NHS and thereby reduce the rate of increase of consumption of tax revenue.
To this end, the reformed NHS places corporate providers (NHS trusts) in the position where they must secure service contracts in a competitive and sometimes volatile market. This in turn has made the question of costs central (rather than incidental) to service delivery with corresponding effects on the distribution of power between managers and professional practitioners (Humphreys 1995a). For our present purposes the significant point of this is that the new nurse needs to be different in various ways to the old nurse, a fact which is manifest in the extensive current debates about skill-mix, role boundaries, nurses as managers, and also ideology and value issues.

The question as to whether a distinct non-medical education market can contribute to these changes now becomes clearer. Furthermore it is not just about a numerically sufficient workforce supply, rather it is as much to do with qualitative features of newly qualified nurses and/or established nurses who have undertaken programmes of professional development. Whatever the pros and cons of NHS reform, if the two markets are not harmonized then the two-market dispensation would be seriously flawed in policy terms, which in turn could impede NHS reform. Although many education providers take care to accommodate the needs of their service recipients (NHS trusts and students) there is evidence to suggest that the NHS trusts are not universally convinced of their commitment to the needs and values of the new NHS.

Alignment issues

In particular, the present author has reported a perception among NHS trust chief executives that a 'political orientation' within NMET can 'protect traditional values or at least hinder the changes they are expected to achieve' (Humphreys 1996). If indeed, orthodox positions incompatible with the new NHS remain ascendant in education and training then harmonized and strategic alignment between the two markets would be impossible.

This point illustrates the dangers of having two distinct markets for closely linked and dependent activities. If the prevailing priorities differ between the two markets (such as one trying to implement NHS reform, while the other implicitly acting against it) then no coherence emerges. Conversely, according to Bartlett & Le Grand (1993) an effective quasi-market generates responsiveness among providers because not to respond may jeopardize the contract: a point which emphasizes the significance of purchasers who, since they control money, may demand and secure high levels of responsiveness to their own agendas. Arguably then, the single most important factor in determining whether the NMET market will vigorously respond to the needs of the new NHS is the inclination and effectiveness of the purchasers in articulating and asserting these needs.

The extent to which regions could fulfil this role effectively was always doubtful. Not only were they considered 'remote from the action' as one trust chief executive put it (Humphreys 1996), but they were also the final remaining element of the old NHS. Consortia, however, are different in both respects. In terms of their composition they represent major elements of the new NHS (including purchasing authorities, GP fundholders and NHS trusts) — a feature which gives them the potential to ensure that NMET is strongly complementary to NHS reform and the ongoing needs of the health service. Whether they achieve this theoretical potential and harmonize the two markets will depend, however, on their operational effectiveness as education commissioners — something which in turn depends on their ability to resolve a number of practical issues.

CONSORTIUM FUNCTIONS AND STRUCTURE

Remaining parts of this paper will examine aspects of consortium structure and function, and their significance in terms of their effectiveness as NMET commissioners. Material for these sections is derived directly from experience in the South East Thames and, subsequently, South Thames Regional Health Authority (SETRHA/STRHA) who set up consortia under the WP10 dispensation, along with a system by which the quality of NMET (as viewed by NHS trusts) could inform the contracting process. This consortium-based system is described by Humphreys & Davis (1995).

Although the consortia in SETRHA consisted only of NHS trust (and regional) representation, the functions envisaged were similar to those specified in the 1995 policy document for new extended consortia. These include estimating training demand on the basis of collated workforce plans, and commissioning education. In the context of the SETRHA consortia these responsibilities were distilled into four consortium functions as follows:

Forward look Including activities related to workforce supply needs and implications for education contracting. This function was considered to include anticipating the need for new courses, preparing to bring new education providers and new professional groups into the consortium contracting process, and generally agreeing priorities for development.

Performance overview This describes a component of the system in which aspects of the 'capability' and 'performance' of education providers were assessed on the basis of systematically achieved information sent up from individual NHS trusts. These quality assessments covered specific aspects of education provision (including recruitment, course content, course delivery and output quality) in addition to general organizational characteristics such as...
responsiveness and flexibility (these measures are detailed in Humphreys et al. 1993).

Contract negotiation and specification Including initial notification of contracting intent, negotiation of terms and conditions, and drawing up contract specifications and documentation.

Financial management Covering all consortium level financial matters including financial planning and budgeting, financial accounting and elements of costing, etc.

In early 1993 a series of consortium development workshops developed a preferred consortium infrastructure which it was felt could effectively manage these functions. This model is shown as Figure 1. In the event, while consortia came to differ in terms of exact structure, a major sub-group constituted a common element (typically called the 'Human Resource and Nursing Committee' or similar).

Consortium structure, however, has proved to be perhaps the least problematic area of consortium development. Through the quasi-market analysis above we have identified the crucial role that consortia must play in harmonizing the two quasi-markets in such a way as to ensure that NMET plays an active part in NHS reform. To achieve this it is necessary that consortia are not only appropriately structured, but also that they perform effectively as education and training commissioners. Three particular aspects of consortium performance derived from experience in SETRHA/STRHA are discussed below.

**COST–BENEFIT RELATIONS AND CONSORTIUM COMMITMENT**

Effective consortium performance does and will depend on the commitment of the members. Experience of consortium development with NHS trust chief executives and other senior trust staff suggests that this cannot be taken for granted. The reasons for this are twofold: Firstly, for all consortium members commissioning of education is secondary to their primary role as health care commissioners or providers. Secondly, in order to 'consort' effectively, some consortium members will sometimes need to set aside organizational self-interest for the greater benefits of collective action. As one trust chief executive put it: 'To get consortium benefits... each trust will need to compromise on its specific needs'.

In order to work together effectively and tolerate these compromises it has become clear that consortium members need to perceive a benefit to health care delivery of sufficient magnitude and direction to justify the costs of participation. In consortium development workshops this cost-benefit question has resolved itself down to two central issues.

1. Is the NMET market sufficiently developed to generate real change in education providers when consortia seek it?
2. Will real powers be devolved to consortia or will regions (or more recently Regional Education Development Groups) merely consider consortium views as one among many views informing the location and nature of contracts?

These points and their significance in determining the commitment within consortia are encapsulated in the following representative quotes from senior NHS trust staff attending consortium development workshops.

How meaningful is a market when consortia are clustered around individual colleges?

Unless there is a reality of control I would not be much inclined to get involved — I've enough trouble with my service contract.

Are we going to have the degree of freedom to derive the benefits or are we just setting up an enormous bureaucracy with little advantage? I would need to see the freedom in order to sign up — Could that degree of freedom be spelt out in a way we could consider it and make a decision.

The decision referred to above was a decision by a trust over whether to bother to participate in a consortium, and

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Figure 1 Example of a preferred consortium infrastructure developed in 1993 during consortia development workshops in the South East Thames Regional Health Authority.
while that choice will not in the future be available, there is little doubt that relatively uncommitted consortium members would lead to low levels of consortium performance.

Obligations and powers

In the South East Thames region negotiations conducted in consortium development workshops led to the formulation of very explicit statements of obligations and powers in relation to consortia on the basis of which trusts could assess the cost–benefit relations of consortium participation. These are shown in Table 2. Although these obligations and powers for consortia have not yet been implemented in full, and to some extent have been overtaken by the merger of regions and subsequently the adoption of consortia as national policy, they were nevertheless effective at the development stage in persuading many trusts to participate. In other words, the cost–benefit balance implicit in these rules and obligations were sufficient to encourage participation. It seems likely that a similar relationship between the costs and benefits of participation will be necessary to ensure the success of the new national consortium policy.

In this respect, it is interesting to note that EL(95)27 does not clearly resolve the issue of how much power consortia will in fact have. While the intended commissioning role of consortia is made clear, there are certain constraints which may tip the balance against high commitment from consortium participants. In the first place, consortium commissioning intentions are referred to as ‘proposals’ which must be agreed by a higher authority: namely the new Regional Education Development Group (REDG) who must ‘advise the regional office on the acceptability of consortia proposals across the region’. Secondly, devolution to a consortium depends on a regional office’s assessment of whether it has ‘robust relationships’ with education providers and ‘adequate arrangements for securing professional advice’. The REDG is also considered to have a role to ensure that there has been adequate professional input to education planning. While these (and other) safeguards may indeed be necessary, such statements are open to wide interpretation especially since REDGs have no centrally determined terms of reference.

### Table 2

<table>
<thead>
<tr>
<th>Obligations and powers</th>
<th>Procedural requirements for consortia and their component NHS trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of consortia powers</td>
<td></td>
</tr>
<tr>
<td>1 Give effective colleges more work;</td>
<td></td>
</tr>
<tr>
<td>2 Keep efficiency savings for other training purposes;</td>
<td></td>
</tr>
<tr>
<td>3 Give less effective and more expensive colleges less work;</td>
<td></td>
</tr>
<tr>
<td>4 Bring in new education providers;</td>
<td></td>
</tr>
<tr>
<td>5 Give contracts to in-house providers if appropriate;</td>
<td></td>
</tr>
<tr>
<td>6 Accumulate a training development fund;</td>
<td></td>
</tr>
<tr>
<td>7 Extend the range of staff groups covered by WP10 contracts.</td>
<td></td>
</tr>
</tbody>
</table>

Procedural requirements for consortia and their component NHS trusts

1 Individual trusts must generate annually qualitative contract specifications with consortium coordination when necessary.
2 Individual trusts must conduct bi-annual qualitative contract reviews with individual colleges.
3 Consortia must implement a 3-year review of ‘core’ funding levels.
4 Both 1 and 2 should be the result of dialogue between trust and college and formally but concisely recorded.
5 Consortia must apply ‘key indicators for change’ to establish training needs or design their own reliable methods of determining workforce supply and training needs.
6 Individual trusts must fulfil their placement contract obligations to colleges.
7 Shifting of contracts from colleges must fall within the ‘rate of change’ limits (to be specified).
8 Shifting of contracts must be preceded by a comparative analysis of college performance against performance of other regional colleges (information provided by region).
9 Consortia must conduct robust formal tendering procedures (involving an analysis of the capabilities and track record of potential providers) for awarding contracts above a specified size to new providers.
10 Consortia must provide region with clear directions with regard to contracts, specifying providers, contract values and breakdown of education and training activities to be purchased.
11 Consortia will provide region with advanced written notice of intended:
   (i) significant shifts in contracts;
   (ii) invitations to tender;
   (iii) addition of new staff groups to WP10 contracts.
12 Consortia must work with region on issues relating to the integration of colleges into HE.
In practice the scope of a consortium's powers will be determined by the confidence that the REDG has in it. Furthermore, commissioning 'decisions', at least in terms of trainee numbers, will be subject to ratification. In this context, the reality of consortium powers is by no means established and, therefore, on the basis of the evidence above, trust chief executives and other members may well need to be convinced of the benefits of seriously committing.

Accepting this argument by implication, EL(95)27 in slightly desperate tone, looks forward to parliamentary approval for 'powers to direct NHS bodies to work together in consortia for education and training purposes'. However, it is difficult to see how such powers could be effective in directing NHS trusts (for example) to (properly) participate in consortia which have no legal status or statutory terms of reference. Furthermore, while participation may be required, only genuine commitment will be sufficient to secure the real effectiveness of the new framework.

NHS TRUST 'AGENDAS' AND CONSORTIUM EFFECTIVENESS

I have discussed how the origin of consortia relates to the principle of devolved rather than centralized responsibility for training. Working Paper 10, for example, emphasized the general principle of the 'responsibility of the direct employer for training decisions' and EL(95)27 s explicit about consortium responsibility for both quantitative and qualitative aspects of NMET provision.

The idea that consortia largely composed of relatively local groups of employers can have a direct influence on qualitative aspects of education and training which they exert through their role as sole commissioners in a quasimarket is as we have seen unique to NMET. Furthermore, if fully and effectively implemented it does constitute a radical break from a centralized position in which national boards and education providers themselves effectively determined the nature of appropriate provision. Notwithstanding the fact, as we have seen, that 'consortia will need to satisfy themselves that they have adequate professional input' (EL(95)27) the potential for consortia to bring about qualitative changes in the nature of education and training seem considerable.

This is not to say that the national boards for nursing, midwifery and health visiting will not remain important in this respect, however, their new 'regulatory' role in a quasi-market is arguably very different to their earlier position of having direct control through the dual mechanisms of approval and funding. Whereas the national boards (and indeed the universities) must limit consortium-driven change to that which remains compatible with broad national comparability, there remains considerable scope for committed consortia to seek and fund practitioner training which differs significantly from past provision. This potential, however, will remain unfulfilled unless consortia fully understand their key position in the market, and can break free from historically based assumptions about the scope of employer influence on NMET. Whether this happens or not will constitute another factor in consortium effectiveness.

Business agendas

One measure of a consortium's perception of the scope of its influence will be the preoccupations revealed in its business agendas. Table 2 identifies four types of issue raised by trust staff for the agendas of six consortium development workshops in 1994 and early 1995. The most frequently occurring issue type is identified as having high incidence on agendas. Issue types 1 and 2 although included for completeness do not concern us here. (Type 1 because it represents the developmental stage of new consortia and type 2 because it relates to quantitative rather than qualitative aspects of workforce supply.)

In the context of this discussion the most significant feature of Table 3 is the comparative incidence of issue types 3 and 4. In fact some agendas exclusively addressed operational features of the education and training service (e.g. student selection, student-staff ratios, clinical placements, etc.) and all largely neglected health service development and the output features of education and training (e.g. such as skill-mix and changes in practice relating, for example, to changing childbirth, etc., and their implications for course content). Essentially discussions focused on education operations, rather than on educational outputs (e.g. the skills of the resulting practitioners) and the strategically significant relationship between these outputs and the current and future needs of the health service.

The markedly greater prioritization of operational rather than strategic features of education may have various causes: not only do operational problems in education impact negatively on trust staff and clinical areas but they also represent the day to day reality of employer-college relationships. Furthermore they are important issues which do need to be addressed. However, such operational issues are arguably only significant at consortium level if they remain unresolved at the lower trust/college level. The danger revealed is that consortia which are unclear of their position in the quasi-market and the consequent scope of their influence will largely restrict their discussions on qualitative features of education to operational issues. In this context consortium-driven change will be superficial — that is to say limited to the operational details of education. Conversely a consortium where the predominant issue types for discussion concentrate on the future nature of health services, the new types of practitioner, and the implications for course content and

Table 3 Categories of agenda issue for consortia with an indication of the frequency with which they were raised by NHS trust staff during consortium development workshops (see text for explanation)

<table>
<thead>
<tr>
<th>Issue types raised</th>
<th>Issue examples</th>
<th>Incidence on agendas</th>
<th>Notes (see text)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Consortium procedures and capability</td>
<td>Role and powers of consortium, Strengthening consortium sub-groups, Developing the contracting process, etc.</td>
<td>Low</td>
<td>Characteristic of newly formed consortia</td>
</tr>
<tr>
<td>2 Workforce supply and NMET demand</td>
<td>Estimation of workforce needs, Collation of numbers, Staff groups</td>
<td>Low</td>
<td>Largely prepared outside the full consortium level</td>
</tr>
<tr>
<td>3 Operational features of the education and training service</td>
<td>Pre-registration student selection, Clinical placements, Location of post-registration training, etc.</td>
<td>High</td>
<td>Effect of type 3 issue predominance will be superficial change, i.e. largely restricted to the education and training service itself rather than contributing to the development of the health service.</td>
</tr>
<tr>
<td>4 Service development and output features of the education and training service</td>
<td>Course content and service enhancement in relation to: Multidisciplinary training, Changing childbirth, Patient-focused care, etc.</td>
<td>Low</td>
<td>Effect of type 4 issue predominance will be deep change, i.e. ensuring NMET makes a positive contribution to the development of health services.</td>
</tr>
</tbody>
</table>

output will, through its commissioning role, generate change which is not limited just to the operational aspects of education but which will impact on and facilitate health service reform and the ongoing strategic development of the individual trusts.

Chief executives' commitment

Evidence from Humphreys (1996) suggests that if chief executives are personally committed to participating in consortium business then the greater prioritization of education operations rather than output would be less likely to occur. This is partly due to their central involvement in the strategic development of their trusts and partly (paradoxically) because they may not know enough about education to get involved in the detailed complexities of education operations (furthermore, they are not directly involved at operational level). A second mitigating factor could be the presence of health service commissioners amongst the new consortium members.

However, Figure 1 indicates how consortium structure may result in much consortium business and consequently agenda setting going on below the most senior levels (in sub-groups). Furthermore, if chief executives (or indeed health service commissioners) are not fully committed to consortia then the strategic imperatives may yet be lost among the detail of educational operations.

CONSORTIA, QUALITY AND EDUCATIONAL INNOVATION

A central condition necessary for the effective operation of markets, is that purchasers have good information on the quality of the service concerned. Williamson (1985) has shown how providers can exploit an informational advantage and exhibit 'opportunistic behaviour' involving, for example, a reduction in costs (to increase surplus income) at the expense of quality. Some level of asymmetry of information between purchaser and provider is however inevitable in a quasi-market (or indeed orthodox markets) for services as the purchaser does not have direct access to information on services costs. In this respect it is important to recognize the complexities of, and the range of approaches to, fully costing particular service operations in a corporate organization — a process that leaves great scope for selection or manipulation of figures if they are to be released to a purchaser.

Although many DHAs did not cost their NMET services prior to WP10, they were at least in a position of direct access to information in a way purchasers could never be. These points need not be taken to imply deceit on the part of service providers for whom costing (especially relating to indirect costs) of particular operations is rarely an exact science. Faced with a request for cost information from purchasers few, if any, would by preference err on the low side. Indeed such an action could be considered financially irresponsible in a corporate organization. Such pressures to give high-side estimates of the costs of a service in
contract negotiations may not be significant in a quasi-market in which a relatively large number of providers compete for business, i.e. competition compensates by tending to drive down prices. However, this is not the general position in NMET where, in many cases, the number of commissioning consortia will be the same as or perhaps no more than double the number of significant providers available.

It appears that these dangers have been recognized by the NHS Executive who have recently agreed a ‘joint declaration of principles’ with the Committee of University Vice Chancellors and Principals (CVCP) relating to contracts between local education commissioners and institutions of higher education (NHS Executive/CVCP 1995). This document states that ‘public funds should be used only in ways consistent with the purposes for which they are provided’ and agrees that ‘this necessitates a clear understanding of the basis of costing and pricing contracts so that education commissioners can make properly informed decisions in determining to which institutions to award contracts’ (paragraph 10). In return for access to such information (among other things) the NHS Executive have limited the risk of providers by specifying minimum contract durations and indemnifying them against a proportion of the costs of losing contracts or reduced contract size (such as redundancy payments). While the NHS Executive will (subject to parliamentary approval) take on these financial guarantees on a national basis it is recognized that they do not substitute for local negotiation ‘which will always be necessary to reflect local circumstances and need’.

In fact in the context of our quasi-market analysis the joint declaration of principles can be seen largely as a set of concessions to the supply side, made in order to reduce the risks to providers of participation. This is particularly clear when it is recognized (as explained above) that despite the best efforts of commissioners to achieve the necessary ‘clear understanding of costing and pricing’, this is unlikely to be genuinely achievable from a position outside the provider organization. In this position of limited competition combined with only questionable access to real provider costs it therefore becomes absolutely necessary, both for the integrity of the market and in order to avoid possible opportunistic behaviour amongst providers, that commissioners achieve a secure view on the quality of the service provided. However, one feature of all education (and indeed health and social care) markets which distinguishes them from many others, is the difficulty of measuring the quality of output. In NMET this output quality essentially concerns the performance of trained personnel in clinical areas — the measurement of which has been shown by Fitzpatrick et al. (1994) to be complex and difficult.

Quality specifications

In the absence of any established and easy measure of output quality in quasi-markets, Propper (1993) has described how quality specifications and measuring tend to be in terms of inputs, that is to say the processes used by the provider in service provision. Evidence reported by Schlesinger et al. (1986), among others, has shown how the introduction of contracting in the United States of America (USA) has led in some circumstances to the suppression of innovation in services. This occurs when commissioners, in trying to establish the quality of the service for contract review purposes, use process rather than output measures as quality indicators. In educational terms, such process measures could include student–staff ratios, teacher qualifications, library and other resources, etc. Normally implicit in such measures is a concept of quality based on orthodox delivery models, i.e. if a course is delivered in a certain way by a certain type of teacher in a certain type of place then it is considered to be good quality. Innovations which implicitly question these assumptions by departing from such norms fall foul of orthodox process measures. So the indirect measurement of (assumed) quality through process measures (rather than direct output measures such as the actual quality of the trained personnel) can effectively suppress innovation.

In considering this point we must distinguish between changes in health service delivery which may or may not be facilitated by education and training (as discussed in the previous section), and innovations in the education and training service itself (discussed here). While innovations in education and training may be directly linked to service delivery matters (such as changes in the content of courses) they can also be entirely distinct from these (such as steps to increase efficiency by reducing unit costs or steps to increase ease of access and availability such as open and distance learning).

Recently reported empirical research by the present author (Humphreys 1996) has shown that trust chief executives are more inclined to prioritize outputs as a measure of education quality than senior trust nurses. The latter group, possibly because they are more familiar with education and training conventions, consistently rate aspects of process more highly as a quality measure. Since consortia are expected to influence education quality and must, therefore, form a view on it, it must be hoped that through their estimation of quality they do not suppress innovation. Arguably, only if they avoid this will they free education providers to experiment and innovate in such a way as to avoid the considerable market pitfalls of provider homogeneity and thereby encourage a diverse and dynamic education service capable of meeting the needs of the new NHS.
CONCLUSION

Generally speaking, with the exception of NMET, employers are not directly involved in commissioning the education and training of professional staff. They are instead typically limited to exerting influence collectively through advisory committees of various types. At a national level they can work through the consultation mechanisms established for example by curriculum agencies (such as BTEC) while at a local level many education providers set up consultative panels to inform curriculum development. In fact, in all other significant mainstream cases of professional education involving the consumption of tax revenue, employers are not directly involved with the commissioning of professional education and training. The concept of commissioning consortia for health care education therefore constitutes a novel departure from the orthodox.

In this context the performance of consortia (and the system generally) is of considerable interest in terms of both education policy and health policy. Not only can it be seen as a ‘national experiment’ in professional education funding (Humphreys & Quinn 1994) but, as we have seen, the performance of consortia across the country will be of considerable significance to the development of the new NHS.

This paper has analysed the position of consortia in terms of quasi-market theory and has raised certain issues relating to the dynamics of consortium functioning which are likely to effect performance. Overall, on the basis of consortium development work in a regional health authority, it is concluded that high performing consortia are most likely to develop where there is a coincidence of (a) genuine devolution of powers to consortia, and (b) employers perceiving education and training as a strategic issue, that is to say highly significant in terms of organizational development in the context of NHS reform. Where these features coincide, the level of commitment to consortia will probably be high and, it is argued, consortia will be less likely to prioritize operational and process features of educational services to the exclusion of strategically significant features relating to education outputs or (to put it another way) the nature of the nurse and nursing in a reformed and developing NHS.

Table 4 Summary of the characteristics of high and low performance consortia

<table>
<thead>
<tr>
<th>Devolved powers</th>
<th>Employer perceptions of the significance of education</th>
<th>Level of commitment</th>
<th>Predominant consortium agenda issues</th>
<th>Qualitative assessment of education performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>High performance consortia</td>
<td>Genuine control and budget holding—little regional office or REDG interference</td>
<td>Education perceived as contributing to organizational development in the context of NHS reform</td>
<td>NHS trust chief executives active in commissioning decisions</td>
<td>Focus on strategic impact of educational services</td>
</tr>
<tr>
<td>Low performance consortia</td>
<td>Partial devolution with ‘hands-on’ regional office and/or REDG</td>
<td>Education as contributing only to a numerically sufficient workforce-supply</td>
<td>Marginal top-level involvement</td>
<td>Focus on education operations</td>
</tr>
</tbody>
</table>

High performance consortia are defined as those in which the commissioning process is used to ensure and guide responsiveness in education providers with consequent harmonization of the distinct health service and non-medical education and training quasi-markets (see text for full explanation).

commissioners must be inclined not only to ensure responsiveness in education providers (i.e. be intolerant of stasis), but also to guide that responsiveness — something which will demand both an articulate expression of needs and a willingness to reach collective positions within the consortium.

Incentives

The incentives for achieving these goals are considerable. Not only is the potential significance of education and training for service quality and organizational development widely recognized (e.g. Fill & Mullins 1990), but consortia who are effective in encouraging direction and innovation in their education providers will help position themselves advantageously in terms of their responsibilities to patients.

As the former deputy director of personnel in the NHS Executive has recently said, 'If these mechanisms are purely about funding the numbers they will have failed — the more exciting thing is funding development' (Rogers 1995b).

References


This is a well presented paper on a highly topical subject matter. The paper is theoretically guided with excellent analysis and discussion. Because of the topicality of the subject matter and the need for readers to understand the key principles of education commissioning by consortia, rapid publication is recommended.
English nurse education and the reform of the National Health Service

John Humphreys
School of Post Compulsory Education and Training
University of Greenwich

Although nurse education is now a mainstream activity in English universities, its penetration into the education literature is limited and there has as yet been little dispassionate analysis of recent policy development in this area. Yet nurses are the most significant occupational group in the provision of direct patient care in the National Health Service (NHS). In 1992, for example, over 200 approved institutions in England were providing basic nurse training to around 50,000 student nurses at a cost of over £600 million a year. This paper reviews and analyses the development of policy in relation to nurse education between 1985 and 1996 and argues that current arrangements for the funding, coordination and provision of nurse education constitute a novel and complex quasi-market. In contrast to recent assertions in the nursing literature, the development of the market is not positioned simply as the result of an explicit neo-liberal agenda for nurse education. Rather it has emerged incrementally as a secondary or incidental result of other major policy agendas during the decade. In particular the paper attempts to show how two distinct policy processes have interacted, one dominated by the professional nursing establishment which has primarily informed the nature of the supply-side of the education market and the other driven by the imperatives of NHS reform which has determined the demand side. It is argued that the resulting dispensation is unique in the extent to which universities are receiving funding from non-DFEE/Funding Council sources, and unprecedented in terms of the direct powers over university provision given to employers (who increasingly are acting collectively as purchasers).

Introduction

On 1 April 1996, the last of the old-style District Health Authority Schools of Nursing were integrated into higher education – a date which marked the culmination of a process of radical change in nurse education extending over the preceding decade. Although nurse education is now a mainstream activity in English universities, its penetration into the education literature remains very limited and despite regular consideration in professional and academic health care journals, there has as yet been little analysis of recent policy development in this area. Moreover the analyses that have been published tend to concentrate on particular aspects of policy which, while they may be important, cannot provide a complete explanation or indeed understanding of the current arrangements (Lathlean 1989, Burke 1995). By reviewing and analysing the process and outcomes of policy development in nurse education between 1985 and 1996 this paper attempts to provide such an explanation while also encouraging increased consideration in the education literature.

Nurses are the most significant single workforce group involved in the provision of direct patient care in the National Health Service (NHS). In 1992 for example the nursing workforce in England (including midwives and auxiliaries) contained over 400,000 staff with a wage bill of over £5 billion per annum (about one fifth of total...
NHS expenditure). In order to meet a workforce supply need of around 20,000 newly recruited registered nurses per year, there were, in 1992, about 50,000 student nurses undertaking basic 'pre-registration' education and training. This major training endeavour involved over 200 approved institutions in England at an estimated cost to the exchequer in excess of £600 million per annum (National Audit Office 1992, ENB 1995).

In 1985 an hierarchically organised NHS included Regional and District Health Authorities, and the education and training of nurses in England followed an essentially in-house model. Typically a District Health Authority (DHA) contained facilities both for the delivery of health care services (including hospitals) and the training of nurses. In institutional terms at least, education and clinical practice were closely linked. Schools of nursing were financed through districts who employed all their staff; directors of nurse education were responsible to nursing services managers; and pre-registration students were employees of the DHA. Nationally, the responsibility for setting standards in nursing and nurse education was (and still is) the responsibility of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), while the English National Board for Nursing, Midwifery and Health Visiting (ENB) had specific related roles including the approval of nursing schools, the validation of curricula, and until recently the funding of certain particular elements of education and training provision. (Department of Health and Social Security 1979).

This paper constitutes an analysis of policy development in relation to nurse education in England over the period 1985 to 1996. It will be argued that during this time two distinct but interacting policy processes have produced fundamental change in the organisation of 'non-medical education and training' generally (a phrase used to describe the training of health care professionals other than doctors and dentists), and nurse education in particular. The paper will attempt to elucidate a process of policy development which has resulted in novel and complex quasi-market arrangements in which relatively local (rather than national) demand-side monopolies purchase education and training services largely from outside the NHS (that is in the university sector). It will also be shown that these arrangements have been in part, an incidental consequence of the larger imperatives of NHS reform. However the resulting education and training market although dependent on, is clearly distinct from, the so called 'internal market' for health care services. A further purpose of this paper is therefore to briefly examine the relation between these new education and training arrangements and the needs of a reformed National Health Service.

Essentially this is a study of policy change driven by, but also constrained within, the imperatives of a major ideologically driven reform. It shows how in the 'fall-out' from major policy thrusts hybrid dispensations can emerge in which new priorities interact with earlier policy directions whose residual momentum is supported by an occupational interest group.

Professional domination of policy: 1985-89

In April 1985 the Royal College of Nursing (RCN) – a professional and trades union organisation – published the findings of its commission of inquiry into the education of nurses (RCN 1985, the Judge Report). The report identified a high wastage rate among student nurses and linked this causally to a shortage of suitable tutors in clinical
areas and the abuse of student nurses through their utilisation as a necessary component of the clinical workforce. The report recommended 'the uncoupling of education from direct and persistent control by service' (15) through 'translation into the mainstream of higher education of the institutions and staffing of nurse education' (47). By this means it was argued that student nurses should be freed from the prior obligations of work in order to concentrate on learning.

These and other RCN recommendations were symptomatic of a growing concern about the ability of nurse education to produce a numerically sufficient supply of qualified nurses with the increasingly sophisticated skills necessary to operate in modern acute and community nursing environments. Moreover some issues raised in the Judge Report constituted long-standing problems with corresponding recommendations going back sometimes as far as the establishment of the National Health Service in 1948. (Briggs 1972, Wood 1947). Although the first to publish, the RCN was not at that time the only organisation scrutinising nurse education. Indeed the UKCC in 1984 had created a climate of review by commissioning its own initiative (known as Project 2000) to determine the nature of education and training which would best prepare nurses to practice in the 1990s and beyond. In this environment the ENB also felt the need to state its position, which it published for consultation in May 1985 (ENB 1985).

In the event, the reports of the RCN, ENB and in due course the final proposals of the UKCC (1987) corresponded in several ways, and represented a broad consensus extending across all the major nursing bodies. Among the recurring features of this consensus was the view that educational standards could best be enhanced by breaking the traditional apprenticeship model and placing training programmes under the control of educationalists. While practical experience in both hospital and community settings was still considered fundamentally important, the students' relationship with the workplace would be significantly different. No longer NHS employees, student nurses would be largely supernumerary and their rostered contribution to patient care would be limited to the later stages of their course. Furthermore, financed through bursaries (maintenance allowances) they would be working towards new diploma level higher education awards. Under Project 2000 the changing demands of a modern NHS would be met by a new type of registered nurse, one who was equipped and qualified in a higher education setting to provide an enhanced service, extending beyond traditional nursing to cover sophisticated clinical practice, health education and community care.

Such proposed changes to nurse education carried significant cost implications. Work commissioned by the RCN identified tuition costs in universities and polytechnics as approaching four times that in schools of nursing. Moreover, assuming a reduction in the value of the productive contribution of students of 60–65%, it was estimated that the NHS would need to recruit 21,000 extra ward staff, incurring 'replacement costs' of £110 m per year (at 1982/83 prices). These extra costs however were offset by a large reduction in payments to trainees as their status shifted from waged employees to bursaried students. Overall with 14,000 qualifiers per year, and at 1982/83 prices, it was estimated that the overall annual aggregate recurrent costs of registered nurse training would rise by around £32 m (Goodwin and Bosanquet, 1986).

Against such extra costs, the proposals to change nurse education did constitute a 'solution' to a long-standing and chronic problem of student wastage. Perceived as being geared to a greater extent towards the educational needs of the students, and
to a much reduced extent towards the day-to-day requirements of health care provision (and DHAs), it was argued that a wastage rate of 20% could be halved. In May 1988 at the RCN Annual Congress, John Moore (Secretary of State for Health) announced the government's broad acceptance of the Project 2000 proposals; £580 million was subsequently committed for their introduction over a ten-year period.

For our present purposes, two aspects of the Project 2000 reforms demand analysis and explanation. Firstly, why and how Project 2000 took the form that it did, and secondly, why was it accepted by the then Conservative government? These issues will be considered in turn.

In retrospect it can be argued that the adoption of Project 2000 as national policy represented a high point of the influence of professional nurses on nurse education. In the first place, although the consensus which it represented extended from staff-side organisations such as the RCN to statutory bodies such as UKCC and ENB, it was nevertheless essentially a professional consensus by virtue of the fact that these statutory organisations were dominated by professional groups. Indeed the constitution of the four National Boards at that time had been set up by Parliament to ensure ongoing control by the professions through a combination of appointed and elected members, the majority of whom would always be nurses, midwives or health visitors.

The interpretation of Project 2000 as a product of professional domination of policy is elucidated when it is considered in terms of theories of professionalism and professionalisation. In simple terms, upgrading the basic qualification and therefore the status of nurses brought them more clearly in line with conventional professions in which professionals are seen as involved in some sort of high-level, theory-based practice which is normally self-regulated and positioned as a service to society. (Bowman (1986) provides an example of this interpretation of professionalism applied to nurses.) In this context it is of interest that in addition to raising the qualifications and therefore the status of nurses, Project 2000 also distanced training from DHA service priorities. In fact, by drawing in higher education institutions and ring-fenced government funding, Project 2000 considerably reduced the influence of DHA’s in which professional power bases had earlier been eroded by the introduction of general managers (Department of Health and Social Security 1983, the Griffiths Report). Such changes can be seen as enhancing autonomy by decreasing non-professional influence over nurse training, an effect which implicitly strengthens the ability of the profession to define its practice with reduced reference to the preoccupations of the employer, for whom a higher status nurse might carry negative complications with regard for example to cost and distribution of work.

So Project 2000 carried the prospect not only of redefining the nurse at a higher level but of providing a clearer means by which that process could be steered by professional rather than employer priorities. This was a process through which the profession could reinforce its core values and reserve for itself new and advanced skills and responsibilities while shedding a number of the relatively unskilled demands of the clinical environment. It was a process reminiscent both of Marxist-derived conceptions of professions based on their success in establishing legal monopolies by means of state licensure (Parkin 1979), and applications of the Weberian concept of ‘social closure’ by which groups seek to restrict access to specific opportunities, such as the opportunity to practice (Weber 1968)).

While professionalisation theory provides a plausible explanation for many of the Project 2000 proposals and the fact that a consensus in favour of them emerged
across the various professionally dominated organisations, it is important not to oversimplify this analysis. In fact, although Project 2000 was in many ways beneficial to the status of nursing, it constituted a threat to large numbers of existing registered nurses who, while retaining full profession status, would increasingly be working alongside younger colleagues with higher education and awards. Although a higher education training for nurses was by no means new (the first pre-registration degree course was established in 1960 (Altschul 1983)), by 1984 it was still available to only 2% of the trainee nurse intake (Goodwin and Bosanquet 1986) and thus did not significantly affect the status and career progression of qualified nurses without such higher education awards. Project 2000 would change this ratio, and although the effect would be delayed (until the first P2000 nurses qualified), and gradual (as they achieved sufficient experience to compete with established colleagues), it nevertheless carried a threat to established registered nurses.

Even more enlightening in terms of our understanding of the nature and extent of the professional consensus, however, was the case of the enrolled nurse. Before Project 2000 the concept of 'nurse' spanned a relatively wide range of skill levels and task types from the second level 'enrolled nurse' to the first level 'registered nurse'. Not only did Project 2000 shunt nurses up the qualifications ladder but it also effectively excluded from nurse status thousands of (lower level) enrolled nurses who were given the choice of 'conversion' to registered nurses (thereby retaining meaningful nurse status) or remaining as part of an ever diminishing and obsolete staff group. Since much of their actual work still needed to be done, the demise of the enrolled nurse can be interpreted as a component of an unusually severe process of professionalisation in which work (and workers) of lesser status were specifically and abruptly excluded from the concepts of nurse and nursing. In the event, a new category of worker - the health-care assistant - was created to fill the gap left by the upwardly mobile nursing profession. Of course the arguments for this reform were not explicitly about professionalisation, and indeed chronic problems were highlighted in relation to 'the use of enrolled nurses at one moment as substitutes for first level nurses, at another as auxiliaries'. Reviewing research evidence, UKCC (1986) took the view that enrolled nurses were not only 'misused' but also 'abused' (by being treated as inferior) and 'denied' opportunities for advancement.

The case of the enrolled nurse reveals something of the limits of the professional consensus around Project 2000. Although the statutory bodies were committed to the changes, the response of representative bodies was variable. While the Royal College of Nursing supported the single grade (RCN 1986), other staff organisations argued the continuing value of the second level nurse and were unconvinced by the arguments for her/his demise. The National Union of Public Employees (NUPE), for example, favoured the retention of the second level nurse (NUPE 1985), and the Confederation of Health Service Employees (COHSE n.d.), while supporting many of the Project 2000 proposals, argued that it left enrolled nurses 'undervalued, rejected and betrayed by their own profession'. An explanation for this discrepancy in the positions of the staff side organisations can be established through consideration of the traditions of these organisations and the consequent nature of their nursing membership.

In fact the RCN originated in 1916 as the consequence of an initiative from senior nurses whose intention was to establish nursing on a fully professional footing. Indeed 'the advance of nursing as a profession' remains an explicit aim in RCN documents such as its Royal Charter. In contrast, the traditions that dominated the mergers
that led to the formation of COHSE in 1946 were those of a more conventional trades union organisation, some of whose membership such as asylum workers and men were in the early days actually excluded from the RCN (Hart 1994). Moreover, these contrasting traditions still informed patterns of nurse membership across the two organisations. While the RCN was still perceived by many as an organisation for 'senior' nurses (MacKay 1989), there is also good reason to believe that a significant number of nurses changed from both NUPE and COHSE to the RCN when they moved into more senior positions, including nurse education (COHSE 1991).

Such considerations are consistent with the view that Project 2000 was essentially the product of a senior nursing establishment rather than of the profession as a whole and that, in fact, the strong consensus that undoubtedly existed in this establishment did not signify universal agreement within the ranks. Indeed, although the extent of disagreement may not be known, it is reasonable to suggest that few enrolled nurses would have actively supported their own alienation from the nursing workforce. In 1987 the NHS employed a total of 279,610 nurses of whom 85,020 were second level. On this basis, it is plausible to suppose that around the time of Project 2000 up to 30% of the nursing workforce would have been against one of the central planks of the Project 2000 proposals. Moreover this figure excludes the substantial number of first level nurses who, as we have explained, may also have felt threatened.

In summary then, we can interpret the content of the Project 2000 proposals as the product of a senior nursing establishment rather than of the profession as a whole and that, in fact, the strong consensus that undoubtedly existed in this establishment did not signify universal agreement within the ranks. Indeed, although the extent of disagreement may not be known, it is reasonable to suggest that few enrolled nurses would have actively supported their own alienation from the nursing workforce. In 1987 the NHS employed a total of 279,610 nurses of whom 85,020 were second level. On this basis, it is plausible to suppose that around the time of Project 2000 up to 30% of the nursing workforce would have been against one of the central planks of the Project 2000 proposals. Moreover this figure excludes the substantial number of first level nurses who, as we have explained, may also have felt threatened.

In attempting to explain this, we will come close to answering our second question — why Project 2000 was accepted by the Thatcher Government.

Consensus for Project 2000 among a nursing establishment spread across the RCN and the statutory bodies is insufficient alone as an explanation for its adoption as national policy. Indeed the most significant thing about Project 2000 was not its character and content so much as the fact that it was accepted and implemented. Reflecting on the progress of reform in the later 1980s, Dolan (1993: 9) considered it 'hard to overestimate the success of nursing when compared to other professions at that time. Faced with a radical Conservative Government that was bent, it would appear, on breaking the power of the professions, nursing uniquely set its own agenda'.

In analysing why this happened, it must be emphasised at the outset that while the nature of solutions assembled by the nursing establishment can be interpreted as part of a professionalisation agenda, the need for change was perceived much more widely than just within the profession. To the high fail rates and unsatisfactory use of enrolled nurses already mentioned can be added significant worries about workforce supply and retention. In the mid 1980s all three reports on basic nurse training had alluded to falling numbers of 18-year-olds and the consequent 'demographic time-bomb' which threatened recruitment to nursing. Furthermore RCN reported in 1987 that each year 30,000 qualified nurses left the NHS. In these circumstances
Salvage (1988) has argued that 'nursing leaders' came to believe that they must 'pre-empt' government action which might involve reducing entry qualifications and thereby 'erode their control over the entry gate to nursing and the nursing workforce'.

Certainly the high political cost to any government of substantial nursing shortages would make some form of action inevitable. Nevertheless the fact that, in these circumstances, as Dolan put it, nursing 'set its own agenda' still remains in need of explanation, particularly since this agenda which included raising the nursing qualification (and by implication the strength of the case for higher pay) lay as a polar opposite to the alternative of reducing entry qualifications to nursing courses. Arguably both approaches would increase the supply of nurses but in contrast to Project 2000, lowering entry qualifications would do so with relatively little cost to the Exchequer.

Against cheaper alternatives, however, was a professional establishment with the advantage of control over the statutory bodies, one of whose functions was to advise parliament on such matters. Furthermore the majority of UKCC members were nominated by the four National Boards ensuring that the Central Council would itself be professionally dominated as well as having a considerable overlapping membership with the Boards (Department of Health and Social Security 1979). This overlapping membership is interesting in that it can be argued as facilitating the effectiveness of a professional nurse establishment which might otherwise be split geographically (across four countries – England, Scotland, Wales and Northern Ireland) or politically (across five otherwise distinct statutory bodies).

Conversely, this level of access to government and to the policy process available to the statutory bodies was not available for those in the nursing workforce opposing Project 2000. Hart (1994), in particular, has shown how the 'oppositionalist' roots of COHSE, as a conventional trades union, left it disadvantaged compared to RCN in terms of its access to and influence over government policy makers. Moreover, while in COHSE the annual conference of elected branch delegates was regarded as the supreme policy maker of the union, the RCN 'Congress' is secondary in policy terms to its Council, a fact which arguably disadvantages dissenting groups. These characteristics of the statutory and representative nursing bodies suggest that while an establishment in favour of Project 2000 would be able to generate and support a strong consensus, those opposing this establishment would (even if substantial in numbers) have little chance of mounting an effective and influential opposition.

In addition to structural matters relating to the distribution of power within nursing, it is also the case that the existence of a new type of relatively low status support worker (the 'aide') in the Project 2000 proposals ameliorated Government concerns about the financial implications of creating an elite high-cost nursing profession. Robinson (1992) has suggested that these new health care assistants (as they are now called), with their National Vocational Qualification (NVQ) may gradually become indistinguishable from nurses without the new higher education awards. Thus a flexible and cheap workforce may emerge, reducing the numbers of more highly qualified Project 2000 trained nurses in the NHS.

Summarising these various arguments concerning the character and acceptance of Project 2000, a picture arguably emerges of a nursing establishment whose consensus derived from a strong desire to enhance the status of nursing and who were capable of carrying forward a severely professionalising agenda even though it would disadvantage a large proportion of the existing workforce. This is not to suggest that
those directly involved did not believe their proposals to be consistent with the interests of patients. There was, as we have seen, a widely accepted need for change. However, as various sociologists have observed, the altruistic motivation often claimed by professional groups, while it may be genuine, nevertheless often serves alternative goals and works effectively as a rationale for the legitimisation of professionalisation (Johnson 1972).

Finally while professionalisation theory can, as above, be used to elucidate the process of policy change in nurse education between 1985 and 1988, it should not be supposed that full professional status for nursing can ever be easily achieved. One of the biggest issues for nursing in this respect is the considerable power of the medical profession, which may mean that nurses must establish new models of occupational authority as alternatives to traditional professional status if they are to make further progress (Salvage 1988).

Unfulfilled aspirations

While the UKCC and the national boards were heavily occupied with the Project 2000 development, the government had decided that the periodic review that non-departmental statutory public bodies are subject to could be put off until after the Project 2000 work had been completed. In 1988, therefore, after ministers had given their agreement to the general thrust of Project 2000, the management consultants Peat Marwick McLintock (PMM) were commissioned to take another look at the roles and effectiveness of the UKCC, ENB and three other UK National Boards. The resulting report was critical of the then current arrangements for the funding of Schools of Nursing in which the National Boards paid for teaching staff involved in basic (pre-registration) training, while the District Health Authorities paid for post-registration training along with indirect costs relating for example to buildings and related services. The particular problem raised was that although the Boards were responsible and accountable for the use of the staff salary monies they provided, the staff concerned were employed by the DHAs. This created two problems. Firstly, since these funds had to be routed through the DHA, the Boards did not directly control their use (i.e. accountability and financial control were not aligned). Secondly the accountability of teaching staff and indeed Directors of Nurse Education was divided between the health authority who employed them and the board who funded them. These features were considered to breach good financial and management practices (Peat Marwick McLintock 1989).

In early 1989 the consultants could identify only 'two dear ways' to improve the situation. The first was to give all the education and training funding to the District Health Authorities who would manage and be accountable for its use in the same way as any other NHS expenditure. The second was for the National Boards to take over the management of schools, becoming employers of their staff and responsible for their premises, etc. In the event, doubting the commitment of the Districts to education and training (having earlier praised the 'dedication and professionalism of the members and officers of all five [statutory] bodies') the final report recommended that the Boards 'be entrusted with the management and ownership of schools' with the consequence that they should 'sever their financial and managerial links with the NHS' (Peat Marwick McLintock 1989).
Had the PMM recommendations been adopted, then the funding, regulation, management and provision of nurse education would all have been in the direct control of statutory bodies dominated by the profession. The English National Board for example would have routinely received funding from the Department of Health; it would have owned all the Schools of Nursing on which that funding was spent; it would have approved these schools and validated their courses as suitable vehicles for nurse education. Additionally it would have been the direct employer of all school staff. The professional control over nurse education would have been virtually total.

Although the product of an independent review, the PMM report can be interpreted in retrospect as the last manifestation of a prevailing ideology of legitimate professional dominance in the field of nurse education. Indeed this was explicit in the terms of reference for the review, assembled by the sponsoring government departments, which required the consultants to 'not challenge the basic principle that the professions should be self regulating', and demanded recognition of 'the responsibility of the statutory bodies to the ... nursing professions'. The tone of these statements was echoed in the eventual report which revealed the desire of the anonymous authors to 'place on record' their support for the principle of professional self-regulation and later to express their commitment with regard to 'preserving the autonomy of the training function'.

The PMM recommendations arguably reveal how such reviews cannot easily be independent of the context and prevailing ideology of their time. Perhaps most revealing in these terms is the question of whether a third serious alternative to the 'two clear ways' for nurse education funding actually existed at the time. Although the Peat Marwick McLintock report raised the possibility of Regional Health Authority (RHA) control of education funding, it was quickly dismissed as raising a 'serious problem' in that such an arrangement (while giving some guarantee that funding would be used appropriately) would separate the funding responsibility from the approval and 'professional advice' function which would (inevitably) be retained by the Boards. In fact even as the consultants conducted their review the publication in January 1989 of the White Paper, *Working for Patients*, heralded a new political agenda and the fundamental reorganisation of the NHS. In the new dispensation the separation of funding from professionally dominated approval processes would not at all be considered a 'serious problem'.

### The marketisation of nurse education 1989–96

In 1988 the third Thatcher administration began a series of radical reforms in key parts of the welfare state. By and large these reforms involved a withdrawal of the state from the direct provision of services. Although state finance was largely retained, state provision would be replaced by systems of relatively independent providers competing to a greater or lesser extent in quasi or conventional markets. The second of these market developments was the National Health Service reform outlined in the White Paper, *Working for Patients*, (Department of Health 1989) and implemented in the *National Health Service and Community Care Act* of 1990. This Act effectively split DHAs into distinct purchaser and provider units, while additionally introducing GP (general practitioner) fundholders who also acted as purchasers of secondary care services (such as hospital treatment). Subsequent to the 1990 Act, the DHAs
in their purchasing role have merged to form larger Health Authorities (Health Authorities Act 1995) while the provision of secondary care services is now the business of self-governing NHS Trusts (Department of Health 1989a).

While DHAs had contained within them both health service providers and nurse education providers there was no particular reason to distinguish clearly between the costs of each service. At that time the funding of nurse education was, as we have seen, derived from a variety of sources and was in fact very complex (Humphreys 1993). Since the schools were by no means financially distinct organisations, their real costs were hidden within the overall financial accounting systems of the DHA (Humphreys 1994). In the context of NHS reform this position was problematic. For the new internal market for health care to operate properly there was a need to make an absolute distinction between the costs of health care delivery and the costs of health care education. If, for example, these monies remained conflated, and the new NHS Trusts as employers were asked to fund training, then they might be tempted to reduce the level (and cost) of training in order to achieve the short term advantage of reduced overall health service prices, at the expense of the long-term necessities of workforce supply and the ongoing professional development of their staff. Or conversely an NHS Trust committed to education and training could, through the extra costs entailed, put itself at an unfair disadvantage in the short term by comparison with another (Stanwick 1994). This possibly corrupting effect on the price mechanism of the internal market for health services was raised in the second working paper relating to Working for Patients, which suggested that ‘to avoid training . . . being cut back it is necessary to remove these costs from [health service] pricing decisions’ (Department of Health 1989b).

The anomalous position of DHAs in relation to nurse education was now clear. In the first place making education funding distinct from health service funding implied different funders. Since the DHAs were to retain the latter role, a new direct funder for education was needed. For related reasons, leaving schools of nursing within districts was also problematic even if the funding role was removed. They would have been in the peculiar position of providing education and training for those employers, the NHS Trusts, from whom they purchased health services. Since education would be one feature affecting the quality of the health services provided by trusts (which in turn would affect their ability to secure contracts), it would have constituted a considerable distortion of the market principle for a district to continue its direct supply of education and training services. Add to this the Peat Marwick McLintock report’s expressed doubts about the commitment of districts to education and training, and the need for a new arrangement was apparent. These arguments, combined with a general desire to leave districts free to concentrate on their new and crucial role as health service commissioners, created an important question: who should fund and provide education and training? Thus the financial and organisational implications of NHS reform had the incidental effect of creating new and fundamental policy issues for nurse education.

As a response to the immediate need to separate out the funding of education and training from health service monies, the Government published a tenth working paper. Working Paper 10: Education and Training (Department of Health 1989c) appeared only two months after the Peat Marwick McLintock report, but its recommendations were fundamentally different. While the PMM report emphasised centralised control of funding, autonomy of the training function, and the merits of professional involvement, Working Paper 10 proposed a devolved approach in
which Regional Health Authorities working in consultation with employers (NHS Trusts) would have the main funding role for both pre and post registration education and training.

The publication of Working Paper 10 marked a turning of the tide in nurse education. Just as Working for Patients had signalled a further shift away from professional dominance in health service delivery so Working Paper 10 correspondingly anticipated a shift in the balance of control over nurse education away from the profession back towards the employers. Needless to say this was resisted by the professional establishment. In the consultation process, UKCC for example stated that it was 'persuaded by the arguments of the Peat Marwick, McLintock Report' but found 'little in the Working Paper that provides arguments of substance' (UKCC 1990). Outside the nursing establishment, however, responses were again more variable, so for example COHSE welcomed 'the fact that education budgets will be clearly defined and protected' (Nursing Standard 1991).

Although it did not attempt to resolve the question of the location of schools of nursing, Working Paper 10 acknowledged that, in the context of NHS reform, they could not remain within districts. In reviewing the possibilities however, Working Paper 10 further revealed the Government's priorities. After expressing concern that 'there is considerable scope for better dialogue between standard-setting and validating bodies on the one hand [UKCC and ENB respectively] and employers on the other', Working Paper 10 implicitly questioned the National Boards' ability to 'maintain professional competences'. This was done by contrasting 'standards' with 'competences' and associating the latter with employers. The improved dialogue called for was therefore arguably a mechanism for keeping the professionally dominated statutory bodies in touch and in line with the needs of employers rather than just the desires or aspirations of the profession. This position, along with expressed concerns over 'conflict of interest' if approval and delivery of nurse education were in the same hands, meant that although Working Paper 10 was open to wide consultation, its publication made the PMM recommendations to locate schools within national boards a highly unlikely prospect. Furthermore Working Paper 10 identified a range of other options for education providers, from establishing self-governing schools through to locations within Regional Health Authorities, NHS Trusts, or higher education institutions. The UKCC's response to these options preferred the National Boards followed by self-governing schools (UKCC 1990).

In February 1991, William Waldegrave (Secretary of State for Health) rejected Peat Marwick McLintock's recommendations and announced the adoption as policy of Working Paper 10. As a central principle, he stated that decisions governing the supply of trained nurses 'should be taken as close to the point of service delivery as possible, to ensure that such decisions are responsive to local needs and to the changing requirements of the employers' (Department of Health 1991). In the same parliamentary answer, while not resolving the issue of college management, he did explicitly rule out the possibility of ENB ownership.

In early 1992, the Department organised a series of consultative workshops involving education purchasers (by now regions) and education providers. Notes from one such meeting, circulated by the ENB (1992), confirmed that continued ownership of schools by districts was considered untenable by the Department who at that time were also verbally ruling out the idea of independent status. In the context of such discussions, higher education was increasingly positioned as the 'preferred natural home' for nurse education and by October 1992 the NHS Management
Executive was advising regions to facilitate 'closer working arrangements' between schools and higher education including 'full integration were appropriate'. (EL(92)70). By 1992 therefore the elements in an incipient market for nurse education had become apparent. On the demand side regional health authorities advised by NHS Trusts would purchase both pre- and post-registration education and training services from a supply side consisting increasingly of major higher education institutions. The ENB would serve a sort of regulatory function through its residual role of validation and approval. In the event this arrangement remained in place until April 1996.

The effects of these developments on the number and nature of education providers can be seen in Table 1 which shows the number of ENB approved organisations over the eleven years from 1985–95. Two sudden drops in the numbers of DHA Schools of Nursing are apparent, one in 1988–89 (the result of new ENB regulations on the necessary size of a viable school consequent on Project 2000 (ENB 1988)) and a second in 1994–95 as large numbers of remaining district schools incorporated into universities.

While the above analysis of policy development shows 1989 to be the starting point of the marketisation of nurse education, this should not be taken to imply that the eventual market dispensation was planned ab initio in the way that NHS reform was itself planned. In fact the period between 1989 (when Working Paper 10 was published) and 1992 (when higher education was positioned as the preferred natural home for nurse education) the market arrangement was emerging incrementally as the consequence of a complex policy process arguably involving a combination of ideology and pragmatism.

In this respect, the inclusion in Working Paper 10 of RHA management of schools as a serious possibility is worth further comment. While recognising that direct management of schools was not a 'self-evident part of the RHA's core function', it was considered as feasible if 'the relationship was through management budgets constructed as contracts'. Indeed it was recognised that 'RHAs will retain many of the necessary skills to manage such contracts through their other training responsibilities'. By leaving open the prospect of regional ownership of colleges alongside the stated preference for regional funding of education, the question of whether there would be a market for nurse education remained unresolved at this time, for whatever the ideological inclination and market rhetoric ('budgets constructed as contracts') direct regional control over both funding and provision would not have constituted any sort of market dispensation. This point is important in demonstrating that in 1989 no final decision had been taken as to whether nurse education should be coordinated through bureaucratic or market means.

Indeed although Working Paper 10 represented a watershed for nurse education, it should be remembered that its primary purpose was not to establish the overall arrangements for education, but rather to ensure that the price mechanism in the main NHS internal market would not be corrupted by education funds. From an educational perspective Working Paper 10 can best be interpreted as dealing with what might be called policy fallout from the large and ideologically driven NHS reforms. As such it represented a health (rather than an education) policy document which marked the starting point of an education policy process operated around the edges of more significant government agendas to do with NHS reform. As a consequence the final market configuration emerged not through any single decision (no document specifying the overall dispensation for nurse education was ever published
Table 1. Numbers of English National Board approved centres for nurse education and training from 1985 to 1995. The sudden drop in Schools of Nursing between 1988 and 1989 was a result of mergers due to new ENB regulations on minimum size for viable Schools. Since then a gradual further reduction between 1989 and 1994 has been followed by a dramatic drop between 1994 and 1995. In 1996 the last of the conventional DHA Schools of Nursing were incorporated into Higher Education Institutions. The recent drop in numbers for the Independent Sector, Special Health Authority, and other categories of College reflects the fact that some of these institutions have also been integrated into an HE institution. The relatively small increase in the number of F&HE approved institutions (compared to the reduction in Schools of Nursing etc) is indicative of the fact that many Universities have incorporated more than one School.

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Source: ENB Archives.
between 1989 and 1995) but by an incremental process dominated and ultimately determined by two distinct and ideologically disparate policy processes. On the supply side, the introduction of the professionally dominated Project 2000 reforms continued to take their course (with the consequence of increasingly widespread and intimate relations between district schools and the mainstream higher education system) while on the demand side, the more recently initiated but contiguous process of NHS reform combined a reduction of National Board (and therefore professional) influence with a total restructuring of the NHS.

In the absence of any evidence of ab initio planning, the development of the nurse education market can be interpreted as an incidental consequence of these two distinct policy processes, neither of which had the overall coherence and configuration of the education dispensation as its primary concern. An interpretation recently implicitly corroborated by John Rogers (former Deputy Director of Personnel, NHS Executive) who during an interview with the author described the resulting dispensation as an 'accidental market' (Rogers 1995b).

NHS Trusts and education purchasing

In May 1993, the final chapter (to date) of education policy development commenced when the Department of Health set up a review to examine progress relating to the NHS reforms and identify areas for improvement. In the light of this review, the Secretary of State determined to streamline the management structure. Continuing the process of reform, it was decided to abolish the Regional Health Authorities and replace them with eight regional offices of a reorganised NHS Management Executive (subsequently renamed the NHS Executive) (Department of Health 1994). Since regions were by then education and training purchasers, in response to the anticipated abolition of RHAs work commenced on yet another framework for planning and commissioning non-medical education and training, the results of which were published in March 1995 (EL(95)27). A principle element of this arrangement (which currently remains in place) includes consortia of NHS Trusts and others. Consortium functions include: collating workforce plans, estimating demand for newly qualified staff and increasingly 'commissioning education direct from education providers'. With regard to non-medical education and training commissioning (including nurse education), it is envisaged that consortia will need to be 'operational budget holders'. A feature which will enable them to 'influence not only numbers, but also quality, admission policies and “fitness for purpose”'. Consortia began to take devolved control of budget holding and contracting from April 1996.

The original conception of consortia as education purchasers can be traced back to Working Paper 10 and the general philosophy enshrined within Working for Patients that operational responsibility should be devolved to the lowest possible level. However, in the case of nursing and various other staff groups, commissioning of education by individual NHS Trusts was not thought appropriate, mainly due to the fact that the qualified professional output of a school would be numerically much greater than the workforce supply needs of any one employer. Because of this, the possibility of employer consortia as commissioning agents had been raised in Working Paper 10, which encouraged (but did not require) regions to set them up. In 1995 the possibility of total devolution to employers was revisited (i.e. letting employers such as NHS Trusts deal individually and directly with education and
training providers). However, in the context of a priority need to maintain a sufficient supply of qualified workforce, total devolution was again not considered a serious possibility on various grounds, including planning (i.e. in a national or at least regional labour market planning for training on the basis of local circumstances is problematic); training efficiency (unit costs would be likely to rise in a market of many small purchasers); and fairness (i.e. turnover and wastage of staff – and therefore the need to purchase training for replacement – being determined by features of the labour market rather than just the employment practices of individual employers) (Rogers 1995a).

With total devolution to employers ruled out, and regions being disbanded, consortia became the favoured option. However, the old Working Paper 10 idea of consortia of NHS Trusts was by then also considered inadequate. It was now felt that in addition to employers’ representation, consortium membership should also include health care purchasing agencies for their long-term knowledge of health service purchasing intentions; social services (in line with the increased community emphasis of the reformed NHS); and private and volunteer sector involvement (Rogers 1995a). In the light of such considerations an expanded consortium concept with wider representation was adopted and made mandatory as a feature of the planning and commissioning of non-medical education and training.

As a consequence of these developments, from April 1996 employers (NHS Trusts) are required to participate in consortia whose role is the commissioning of education from universities. As such, when contributing to purchasing decisions they must consider the quality and cost effectiveness of the provision of particular universities. Bearing in mind the size of the contracts for which consortia are responsible, it is arguable that there are no precedents in the field of mainstream pre-service higher education in terms of the direct and considerable powers that employers now (collectively) have over universities. The nature of this relationship and some of its implications can be ascertained through an analysis of the market structure.

The nature of the market

In an orthodox market for services a supply side addresses the needs of a demand side composed of consumers making purchasing decisions. In the absence of a monopoly, consumer choice signifies competition between providers who seek to secure or expand their market share. In conventional markets, the purchaser is also normally the direct user or recipient of the service. However in the NHS internal market the purchaser is not the recipient. Instead districts are given the role of purchasing health services on behalf of their local communities who at the point of access become consumers. Since the decisions of purchaser-recipient consumers are central to conventional market theory, markets in which purchasing and consumption are distinct cannot be analysed in orthodox terms. Such arrangements have been described by Le Grand and Bartlett (1993) as ‘quasi-markets’.

Table 2 shows the basic components of conventional and various quasi-markets. In the conventional market (shown for comparative purposes) the purchaser and recipient functions reside within a single individual or organisation who exchange money for the desired service. In contrast the three quasi-markets illustrated show the primary purchaser and recipient functions to reside in separate demand side participants. On the supply side, while conventional markets normally have privately
Table 2. Comparisons of the complex quasi-market for non-medical education and training with the relatively simple quasi-markets for health care and pre-employment higher education generally. In a conventional market the consumer is both purchaser and recipient of the services. In many quasi-markets however these functions are partially or completely distinct. The non-medical education and training quasi-market can be seen to be complex on the demand side where student consumers receive education and training (Recipient B) while NHS Trusts receive workforce supply (Recipient A). (see text for detailed explanation. Adapted and expanded from Humphreys 1996a)

<table>
<thead>
<tr>
<th>Market type</th>
<th>Demand side</th>
<th>Supply side</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional Service Market (for comparison)</td>
<td>Single Purchaser-Recipient</td>
<td>Private, Profit Organisations</td>
<td>*Aggregate purchasing decisions of purchaser-recipients determine who supplies</td>
</tr>
<tr>
<td>Simple Quasi-Market (Health Care)</td>
<td>Purchaser (e.g. Districts)</td>
<td>Public, Non-Profit Organisations</td>
<td>*Recipient decisions have limited direct effect on supply side</td>
</tr>
<tr>
<td></td>
<td>Recipient (Patients)</td>
<td>(e.g. NHS Trust)</td>
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<tr>
<td>Complex Quasi-Market (Non Medical Education &amp; Training)</td>
<td>Purchaser (Region or Consortium)</td>
<td>Public, Non-Profit Organisations</td>
<td>*Recipient A may have significant direct influence on who supplies due to representation on purchasing consortia</td>
</tr>
<tr>
<td></td>
<td>Recipient A (e.g. NHS Trusts)</td>
<td>(Universities etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recipient B (Students)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Quasi-Market (Higher Education)</td>
<td>Purchaser (Funding Council)</td>
<td>Public, Non-Profit Organisations</td>
<td>*Recipients have traditionally been financed with mandatory grants, but are increasingly taking a direct purchasing role. In any event employers are rarely involved directly in pre-service education market transactions (see text).</td>
</tr>
<tr>
<td></td>
<td>Recipient (Students)</td>
<td>(Universities etc.)</td>
<td></td>
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</table>
owned for-profit providers, the public service quasi-markets often have government
owned non-profit organisations (such as NHS Trusts or universities).

In addition to showing these distinctions between conventional and quasi-
markets, Table 2 also indicates an important difference between two relatively
standard quasi-markets (for health services and most higher education) on the one
hand, and non-medical education and training (including nurse education) on the
other. Essentially, for non-medical education and training, a more complex demand
side has two recipients. Firstly the NHS Trust employer for whom pre-registration
education and training fulfil workforce supply services (Recipient A) and secondly
the student consumer seeking the qualifications and skills necessary for clinical practice
(Recipient B).

It is important to note why the positioning of the employer as a direct (rather
than only indirect) recipient of pre-service education and training services is argued
only for the non-medical education and training market and not for the general
higher education market. This difference is a consequence of the devolved (rather
than national) nature of the non-medical education and training market combined
with the fact that non-medical education and training is a ‘monotechnic* market in
which only those subjects of relevance to one type of employer (health care provider
organisations) are purchased. In the context of an historically close relationship
between health care educators and health care providers (and the consequently highly
integrated nature of theory and clinical practice in many nursing courses) these
two features of the non-medical education and training market have so far ensured
that individual nurse education provider organisations remain in very close relation­
ship with their local employer ‘clients’ (the NHS Trusts). Furthermore the direct
nature of this link in market terms was signified by encouragement in Working
Paper 10 for regions to involve employers in purchasing decisions, and was eventually
formalised by the establishment of commissioning consortia as mandatory by
EL(95)27.

Overall therefore the arrangements for non-medical education and training con­
stitute a quasi-market in which the presence of employers adds a novel complexity
to the demand side. This unique market structure raises two immediate questions:
firstly regarding the effects of demand side complexity per se and secondly concerning
the unusual powers of employers in the market (and the implications of these powers
for the supply side).

A degree of demand side complexity is a feature even of relatively simple quasi-
markets, as a direct consequence of the separation of purchaser and recipient functions.
In the health service market, for example, there has been much discussion regarding
the extent to which purchasing agencies can be regarded as purchasing on behalf of
local communities, rather than simply addressing their own or the Government’s
agenda. In the case of non-medical education and training, it might be supposed that
the presence of three demand side components might exacerbate such problems,
although in the event, there is as yet insufficient evidence to attempt an assessment of
the nature and significance of student decisions within this complex quasi-market.

However a point of particular interest is the fact that the complex demand side
includes two types of organisation (regions, or more latterly consortia, and NHS
Trusts) rather than only one organisation and one group of individuals (such as stu­
dents or patients) as is the case in the other quasi-markets shown in Table 2. This fea­
ture raises the particular issue as to whether the organisational priorities and even
ideologies of the demand side organisations are aligned in the purchasing process. In
this respect, work reported by the present author has revealed some scepticism amongst NHS Trust chief executives in the South East Thames Regional Health Authority. While many chief executives accepted the potential significance of education and training for both quality of service and the strategic development of their corporate organisations (part of an ideological position referred to as 'corporate instrumentalism' in Humphreys 1994 and 1996), and also believed in the capability of markets in general to ensure responsiveness in providers, they nevertheless doubted whether the particular arrangements under Working Paper 10 would be effective in ensuring that nurse education providers would produce the sort of new practitioners needed for a reformed NHS.

To appreciate this point, we must rehearse the fundamental nature of NHS reform: with NHS Trusts now operating in their own competitive quasi-markets, the question of costs has become central (rather than incidental) to service delivery. One effect of this has been to create the need for new approaches to the delivery of care with consequent shifts in the nursing role. The need for and nature of these new approaches to nursing are manifest in the extensive current debates within nursing about skill-mix, role boundaries, nurses as managers, and also ideology and value issues. In this context, NHS Trust chief executives were found to be sceptical about the appropriateness of regions as education and training purchasers, feeling that they would be 'out of touch', 'remote from the action' and consequently unable to purchase on the basis of a full knowledge of the 'real world priorities' of NHS Trusts. Furthermore for some chief executives the Working Paper 10 quasi-market constituted a mechanism through which Regional Health Authorities would inevitably (although not necessarily intentionally) prioritise the professional 'territorial rights' of nurses above the needs of a reformed NHS and its Trusts (Humphreys 1996). For a significant proportion of these chief executives the arrangements for nurse education were flawed to such an extent that they favoured the replacement of Working Paper 10 with a conventional (rather than quasi) market in which all monies for education and training were disbursed amongst individual trusts for direct purchasing from education providers.

Thus the complex non-medical education and training quasi-market under Working Paper 10 did indeed have severe tensions on the demand side — created not as a consequence of there being three demand side participants but rather due to the fact that two of these demand side participants were organisations, who arguably differed in their priorities.

In the event, since the implementation of Working Paper 10 was devolved to regions, efforts to develop a unitary view on the demand side took various forms. While in some regions this was achieved by default — NHS Trusts never really being encouraged to participate in anything other than calculating their numerical workforce supply needs — other Regions saw the invitation to create employer consortia within Working Paper 10 as an appropriate response. By establishing such consortia of employers and giving them a range of significant powers over education commissioning and the location of contracts, the prospect of a coherent demand side emerged (Humphreys and Davis 1995).

Table 3 shows how the devolution to Regions of Working Paper 10 implementation led to great variations between the character of the English regional markets which ranged from fully reformed demand-dominated systems to 'soft' markets in which historical patterns of delivery were largely maintained until relatively late in the reform process. In fact in their most strident manifestation Working Paper 10
Table 3. Some dimensions of market character under Working Paper 10. This table illustrates the extent to which the devolved implementation of Working Paper 10 allowed considerable variations in practice and market character across different Regional Health Authorities.

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<tbody>
<tr>
<td>Regional Staffing</td>
<td>Individual Trust Involvement in Contract Specification</td>
<td>Trust Consortia</td>
<td>Location of School</td>
<td>Commissioning Process</td>
<td>Contract Characteristics</td>
</tr>
<tr>
<td>Reformed ‘demand’ dominated market</td>
<td>Independent of supply side often with newly appointed staff</td>
<td>Quantitative &amp; qualitative (e.g. skill mix specification)</td>
<td>Established with devolved powers</td>
<td>Early relocation of district schools into universities often with consequent redundancy</td>
<td>Hard and competitive (e.g. whole contract tenders)</td>
</tr>
<tr>
<td>Historical ‘command’ dominated market</td>
<td>Staffing overlap between demand/ supply sides e.g. Education provider staff seconded to Regional commissioning teams</td>
<td>Tentative involvement (in quantitative issues only)</td>
<td>Unestablished</td>
<td>Schools retained by districts until all other options finally gone</td>
<td>Soft and historical with existing providers</td>
</tr>
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consortia drew a line under historical patterns of provision and put all contracts out to national tender.

Regardless of the severity or otherwise of particular regional markets, the implementation of Working Paper 10 brought all education providers to a greater or lesser degree within the scope of market forces. For many providers the reality of this new market became a tangible feature of their environment at the point at which they left the District Health Authority and found themselves outside the NHS. With an accumulating professional literature analysing the significance of the changes for providers, it became widely recognised as 'probable that the institution which continues in a basically reactive mode is unlikely to weather the storm of change' (Fields 1991). Therefore, in the context of a 'marketing gap' between the necessary new approaches and the established practices of many colleges (Humphreys 1993), restructuring associated with college mergers and/or the incorporation into universities was also sometimes used as an opportunity to develop new management structures more appropriate to the prevailing circumstances (Ramsammy and Humphreys 1994).

At the centre of these changes were (and are) the individual nurse teachers struggling to identify a new role. Conventionally positioned as a specialism of the nursing profession, they served (among other things) to socialise new recruits into the long established value systems of professional nursing, a role which, despite the tensions identified by Peat Marwick McLintock, was broadly compatible with their position as NHS employees. In 1996 however, the vast majority are employed outside the NHS (in universities) and answerable through the market to the unfamiliar ideologies of corporate NHS Trusts. These Trusts, as we have seen, have considerable degrees of power within the market and are likely to press for change in nurse education (and the resulting nurses) in ways more compatible with their own corporate imperatives than the prevailing professional priorities implicit in the conventional nurse tutor role. Thus in accommodating their new positions and reconciling the diverse tensions upon them, nurse teachers will need to establish new approaches to curriculum development (Humphreys 1994) and, more fundamentally, new paradigms within which to practice. There is some evidence that these changes are indeed occurring (Humphreys 1995).

In considering the nature of the nurse education market it is necessary, in addition to analysing its structure and the qualitative features of its demand and supply sides, to consider its actual performance as an effective means of coordinating services. Currently available sources of information in this respect are limited and as yet unreliable, but some evidence is available. Table 4 shows the total number of entries onto pre-registration nurse training courses in each of the ten years from 1985 to 1995. In addition to revealing the effects of professionally led policies such as the replacement of conventional courses with Project 2000, and the cessation of level 2 training, the figures also reveal a significant downturn in first level entry from a high point of 16,864 in 1991–92 to 10,844 in 1994–95 (the last year for which figures are available). While this downturn coincides reasonably well with the introduction of Working Paper 10, the devolved (regional) implementation and consequently different approaches revealed in Table 2 make interpretation difficult in the absence of further research. Furthermore the extent to which this reduction constitutes an improved coordination of supply and demand also remains to be seen, as does any analysis of whether the market dispensation is more effective in this respect than the earlier bureaucratic means of coordination.
Table 4. Total numbers of entries into pre-registration nurse training from 1985/6 to 1994/5. Three major trends are apparent. 1) The reduction in entry to Level 2 training (lines 12–15) between 1985 and 1991 caused initially by uncertainty surrounding the future of enrolled nurses followed by the acceptance of the Project 2000 reforms. 2) The gradual replacement of traditional registered nurse training programmes (lines 1–5) with the new Project 2000 courses leading to HE awards (lines 6–10). 3) The pronounced downward trend in level 1 entries commencing in 1992/3 after a long period of stability: an effect coinciding with the introduction of the Working Paper 10 quasi-market.

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<tr>
<td>('Registered Nurses')</td>
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<tr>
<td>1 General</td>
<td>13,128</td>
<td>12,985</td>
<td>12,403</td>
<td>12,882</td>
<td>12,907</td>
<td>8,824</td>
<td>6,390</td>
<td>3,348</td>
<td>577</td>
<td>53</td>
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<tr>
<td>2 Mental Illness/Mental Health</td>
<td>1898</td>
<td>1836</td>
<td>1796</td>
<td>1774</td>
<td>1719</td>
<td>1239</td>
<td>898</td>
<td>422</td>
<td>100</td>
<td>10</td>
</tr>
<tr>
<td>3 Mental Handicap</td>
<td>786</td>
<td>924</td>
<td>816</td>
<td>866</td>
<td>726</td>
<td>445</td>
<td>282</td>
<td>116</td>
<td>3</td>
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<tr>
<td>4 Sick Children</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>107</td>
<td>110</td>
<td>53</td>
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<tr>
<td>5 Comprehensive RGN/RSCN</td>
<td>277</td>
<td>202</td>
<td>187</td>
<td>183</td>
<td>78</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<tr>
<td>6 P2000 Adult</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>713</td>
<td>3219</td>
<td>610</td>
<td>8186</td>
<td>8186</td>
<td>7245</td>
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<tr>
<td>7 P2000 Mental Health</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>144</td>
<td>3630</td>
<td>1297</td>
<td>1668</td>
<td>1598</td>
<td>1407</td>
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<td>8 P2000 Mental Handicap/Learning Disability</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>41</td>
<td>233</td>
<td>517</td>
<td>649</td>
<td>488</td>
<td>414</td>
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<td>9 P2000 Childrens</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>50</td>
<td>270</td>
<td>503</td>
<td>819</td>
<td>857</td>
<td>914</td>
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<tr>
<td>10 Common Foundation Programme</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>122</td>
<td>482</td>
<td>760</td>
<td>711</td>
<td>654</td>
<td>798</td>
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<tr>
<td>11 SUB-TOTAL</td>
<td>16,089</td>
<td>15,948</td>
<td>15,202</td>
<td>15,905</td>
<td>15,797</td>
<td>15,452</td>
<td>16,864</td>
<td>15,921</td>
<td>12,464</td>
<td>10,844</td>
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<tr>
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<tr>
<td>12 General</td>
<td>4166</td>
<td>3628</td>
<td>2266</td>
<td>1512</td>
<td>480</td>
<td>61</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>13 Mental Illness/Mental Health</td>
<td>680</td>
<td>512</td>
<td>191</td>
<td>100</td>
<td>54</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>14 Mental Handicap</td>
<td>191</td>
<td>202</td>
<td>117</td>
<td>70</td>
<td>53</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>15 SUB-TOTAL</td>
<td>5037</td>
<td>4350</td>
<td>2597</td>
<td>1683</td>
<td>587</td>
<td>61</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
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<tr>
<td>16 GRAND TOTAL</td>
<td>21,126</td>
<td>20,298</td>
<td>17,799</td>
<td>17,587</td>
<td>16,384</td>
<td>15,513</td>
<td>16,864</td>
<td>15,921</td>
<td>12,467</td>
<td>10,846</td>
</tr>
</tbody>
</table>

1. The very small numbers commencing training on Level 2 programmes in recent years include those with extended absence along with failed Level 1 candidates.
2. The drop in Level 1 entry is likely to be compensated for in the short term by Level 2 – Level 1 conversions (“Enrolled Nurse conversion”) but figures are not published for this activity.

Conclusion

From the above elucidation and analysis of nurse education policy between 1985 and 1996, it is possible to derive two general points. Firstly that the policy process in relation to nurse education was in various ways peculiar, and secondly that the dispensation resulting from that process is in various ways unique. Essentially a quasi-market, in which a complex demand side gives employers considerable collective power as purchasers, has arisen from a severely incremental policy process involving the interaction of two policy agendas — neither of which had the nature of the resulting overall dispensation as its primary concern. In some ways the current arrangements can be interpreted as hybrid — lying somewhere between conventional models of professional education provided by universities and funded ultimately by the Department of Education and Employment (such as architecture) and high-level in-house training funded and provided by corporate employers (such as commercial pilots).

The concept of non-medical education and training as a hybrid dispensation elucidates many of its peculiar features. In particular its demand side complexity (due as it is to the direct involvement of NHS Trusts) can be interpreted as counterbalancing the professional domination of standard setting (UKCC) and approval (ENB), although falling short of devolving completely to individual employers. Similarly the considerable (and in various senses professionalising) influence of the universities as providers, located as they are outside the NHS, is balanced by the retention of funding within the NHS. Indeed in this latter respect it is reflective of the hybrid nature of the policy that there appears to be no comparable national or even international examples in the sphere of mainstream higher education provision where so much tax revenue is spent through one government department (Health) on a service provided by institutions effectively owned by another (Education and Employment). In Australia, for example, when nurse education shifted into universities, funding was correspondingly transferred to the control of the education department (Parkes 1986), an action which would equate to transferring nurse education funding to the Higher Education Funding Council for England.

This analysis raises the question as to whether the nurse education market is by its nature in a position to respond effectively to the new needs of employers going through the process of radical NHS reform. Considering the significance of NHS reform which we have discussed in terms of changes in nurse skill-mix, role boundaries, nurses as managers, value issues, etc., the challenge for the non-medical education and training quasi-markets clearly goes well beyond the simple production of a numerically sufficient workforce supply. Crucially therefore the education and training quasi-market must be capable of coordinating not only quantitative but also qualitative features of the nurse output with new patterns of demand.

However, we have seen also that health care services and nurse education are now coordinated through clearly separate quasi-markets with separate funding — distinct demand-side components and supply-side organisations separated not just by their traditions and corporate individuality but also by the fact that they fall under different government departments. Whatever the pro's and con's of NHS reform, if these two markets are not harmonised (i.e. the smaller nurse education and training market meeting needs generated in the larger health service market) then the two-market dispensation would be flawed in policy terms, and this in turn could impede rather than facilitate NHS reform. Furthermore this question mark over the capacity of the
two-market arrangement to generate harmonisation (and therefore a good match between qualitative aspects of workforce demand and supply) is not simply hypothetical. We have discussed evidence of tension within the complex demand-side of the non-medical education and training quasi-market and indeed some NHS Trust chief executives are known to believe that a 'political orientation' within non-medical education and training can 'protect traditional values or at least hinder the changes they are expected to achieve' (Humphreys 1996).

The possibility of nurse education doing anything other than facilitating NHS reform raises the question as to what exactly were the priorities of government in 1989 when, through Working Paper 10, the Department of Health significantly changed the direction of policy. A conventional answer to this question in the professional and academic nursing literature is that Working Paper 10 was designed to bring the New Right ideology to bear on nurse education. Burke (1995), for example, positions Working Paper 10 as 'an attempt to introduce the purchaser/provider split into NHS education and training' and she goes on to interpret Working Paper 10 in terms of the detailed principles of Conservative Party social policy at that time. Implicit in such analyses are rational models of policy decision-making in which policy development is analytical and goal-oriented. In fact, as has been shown above, Working Paper 10 can best be interpreted not so much as an ideologically driven document moving towards Conservative Party ideals but rather as focused on immediate concerns and moving away from a problem rather than towards any particular educational goal, features which position it squarely as incremental in policy theory terms (Gregory 1993, Braybrook and Lindblom 1963). Furthermore the problem Working Paper 10 was designed to overcome was not just an educational problem (such as wastage) but one relating to NHS reform (namely the distortion of the price mechanism in the 'internal market' for health care) — hence our reference to 'policy fallout'. So, whereas it may be possible to see Working Paper 10 as part of a rational and goal-oriented process in relation to Health Policy, it should not be interpreted primarily as a rational attempt to inject New Right principles into nurse education.

All of this demonstrates that Working Paper 10, although pivotal for nurse education, was essentially a pragmatic document laced with some New Right rhetoric. This is not to say however that some of what Scott (1996) has called the 'deep structure' of Thatcherite opinion was not apparent in it (such as respect for employers, suspicion of professions, etc.) but in the last analysis, it did not commit nurse education to a market arrangement. Therefore to properly understand the development of the current arrangements for nurse education, it is necessary to avoid the beguiling rationality that positions the nurse education market as an explicit goal of a Thatcher government. Rather one must look back beyond 1989 and recognise that the components and character of the market for nurse education are arguably as much an unintended consequence of the aspirations of the nursing establishment as they are an incidental consequence of neo-liberal reforms in health care.

References


The commissioning of nurse education by consortia in England: a quasi-market analysis

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INTRODUCTION

The supply of nurses in the United Kingdom (UK) is largely dependent on the output of nurses from pre-registration, 'Project 2000' courses (UKCC 1986). This educational activity feeds a pool of qualified nurses from which National Health Service (NHS) trusts and other health care providers recruit. Thus nurse training activity is integral to the labour market for nurses, with the consequence that planning of nurse supply to meet the demand of employers must provide some means by which the quantitative needs of employers inform the number of students trained. Since 1991 the device established to co-ordinate these has been a quasi-market (Le Grand & Barlett 1993).

Quasi-markets

Since the NHS and Community Care Act's (1990) creation of the purchaser-provider split in British health care, the co-ordination of health care services has comprised an 'internal market' (Holiday 1995). The market is internal,
because it is largely located within the NHS. This internal market is like conventional markets in that it involves contracting and elements of purchaser choice, and therefore involves competition. However, the internal market differs from conventional markets because the purchaser is not the direct recipient, or user, of the service. Rather, general practitioner fundholders and others purchase on behalf of their local community, the members of which become consumers as they use the health service.

As the purchasing choices of consumers are pivotal to conventional market theory, Le Grand and Bartlett (1993) argue that such theory is inadequate to analyse markets in which purchasing is distinct from consumption. They term the latter ‘quasi-markets’. The arrangements for nurse education comprise a complex, and distinct, quasi-market. Table 1 compares the central elements of a conventional market, the quasi-market in healthcare, and the complex quasi-market in nurse education.

Table 1 illustrates the difference between conventional and quasi-markets, in that where a single purchaser-recipient exchanges money for services in a conventional market, in both quasi-markets the purchasers and recipients are distinct, and where the supply side in the conventional market is privately owned, in the quasi-markets supply is publicly owned.

Table 1 also demonstrates an important difference between the two quasi-markets. While the quasi-market in health care has one set of recipients (patients), the quasi-market in nurse education has two — the NHS trusts and other healthcare providers for whom nurse education provides a workforce (recipient A), and the students (recipient B) to whom education provides skills and qualifications. Moreover, Humphreys (1996a p. 1291) observes a further peculiarity in this quasi-market, in that, ‘positioning the employer as a direct (rather than only indirect) recipient of services could not be effectively argued in most other major education and training quasi-markets’. He argues that nurse education differs from other further/higher education quasi-markets because of the close relationship between the education provider and the employer, and the devolved nature of the purchasing function. Thus the arrangements for nurse education constitute a complex quasi-market, which has important differential features from its contemporary quasi-markets in health care and education.

**Policy background**

Greater competition between providers of nurse education was advocated in the document *Working Paper 10: Education and Training* (Department of Health 1989a), which reviewed the then arrangements for nurse education in the light of developing NHS reforms. *Working Paper 10* was adopted as policy by the Conservative government in February 1991. We describe the process nurse education has undergone since then as one of ‘marketisation’, in that it has involved the introduction of an internal quasi-market, as well as the promotion of discourses of efficiency and ‘value for money’ through competition. By 1992 the elements of a market were in place, with the majority of supply being located in higher education, providing nurses to the demand of Regional Health Authorities (RHAs) and NHS trusts. Working Paper 10 introduced the notion of consortia as the ‘ideal’ commissioning agents for nurse education, and when in 1993 the RHAs were replaced by eight Regional Offices of the NHS Executive, the formation of the consortia mechanism for nurse educational commissioning began. Since April 1996 it has been the job of these groups to commission nurse education, and to co-ordinate the healthcare workforce demand for new nurses with an expression of demand for nurse education.

The notion of consortia reflected the general philosophy of devolvement of operational responsibility in health care which was articulated in the Government white paper *Working for Patients* (Department of Health 1989b, see Burke 1995). In light of the intention to abolish Regional Health Authorities (the then commissioners of nurse education), a new framework for the commissioning of nurse education was introduced in February 1991. We describe the process nurse education has undergone since then as one of ‘marketisation’, in that it has involved the introduction of an internal quasi-market, as well as the promotion of discourses of efficiency and ‘value for money’ through competition. By 1992 the elements of a market were in place, with the majority of supply being located in higher education, providing nurses to the demand of Regional Health Authorities (RHAs) and NHS trusts. Working Paper 10 introduced the notion of consortia as the ‘ideal’ commissioning agents for nurse education, and when in 1993 the RHAs were replaced by eight Regional Offices of the NHS Executive, the formation of the consortia mechanism for nurse educational commissioning began. Since April 1996 it has been the job of these groups to commission nurse education, and to co-ordinate the healthcare workforce demand for new nurses with an expression of demand for nurse education.

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**Table 1** Comparisons between a conventional market, the quasi-market in healthcare, and the quasi-market in nurse education (from Humphreys 1996b)

<table>
<thead>
<tr>
<th>Market type</th>
<th>Demand side</th>
<th>Supply side</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional market</td>
<td>Single purchaser-recipient</td>
<td>Private, profit organizations</td>
<td>Aggregate purchasing decisions of purchaser-recipients determine who supplies</td>
</tr>
<tr>
<td>Quasi-market in healthcare</td>
<td>Purchaser (e.g. GP fundholders)</td>
<td>Public, non-profit organizations (e.g. NHS trusts)</td>
<td>Recipient decisions have limited direct effect on supply side</td>
</tr>
<tr>
<td>Quasi-market in nurse education</td>
<td>Recipient (patients)</td>
<td>Recipient A (e.g. NHS trusts)</td>
<td>Recipient A may have restricted influence on supply side due to representation on purchasing consortia</td>
</tr>
</tbody>
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Recipient B (students) | Public, non-profit organizations (universities, etc.) | | |

education had to be devised. A belief in the free-market and a supposed drive for devolution (e.g. ‘rolling back the frontiers of the state’) were embraced in Government thinking at the time (see Burke 1995, Walford 1996). One might have assumed this thinking would have led to the total devolution of commissioning to employers, with NHS trusts and other employers dealing directly with higher education institutions. Indeed, Humphreys (1996a, 1996b) claims that this option was considered, but was eventually rejected due to the various possible impediments to maintaining a sufficient workforce supply (the priority need) which such arrangements might entail. These included issues of planning and training efficiency. Hence, with the idea of total devolution rejected, the notion of consortia became a favoured option. Humphreys argues that the development of commissioning to consortia can be seen as a consistent expression of Conservative policy, where enthusiasm for devolution has been moderated by the necessity of efficiency and long-term planning in a national market.

CONSORTIA AND THEIR FUNCTIONS

The outline of the new framework for nurse education commissioning, in which consortia comprised a principle element, was published in the NHS Executive (1995a) document EL(95)27, in March 1995. Consortia are groups representing health care providers and purchasers in particular geographical areas: each consortium should include a representative from each trust in the area, one from each health authority, representatives of GPs (including GP fundholders), a representative of each social services authority, and representatives from the private and voluntary sectors (see NHS Executive EL(95)27).

Two of the main tasks of consortia are listed in EL(95)27 (NHS Executive 1995a pp. 3–4) as, ‘collating workforce plans... and turning this into an expression of demand for newly qualified staff at a later date’ and increasingly commissioning education ‘direct from education providers’. Consortia began to play a significant role in educational contracting from April 1996, and their increasing control is a phased process. A performance management framework is being developed to support this phased devolution of control (see EL(97)30, NHS Executive 1997), and some consortia will be given full educational purchasing powers from April 1998.

EL(95)27 (NHS Executive 1995a) suggests a qualitative function for budget-holding consortia in their potential to influence the ways in which the non-medical workforce is trained, and the type of workforce subsequently produced. This paper is focused primarily on the quantitative aspects of consortia, in terms of their ability successfully to co-ordinate supply and demand concerning nurse student places. However, the qualitative aspect has been considered elsewhere (see Humphreys 1996a, Snell 1997) and a brief discussion of qualitative issues is included in our analysis.

Quasi-market co-ordination requirements

In order for the quasi-market in nurse education to function effectively, the demand for nurse training places must co-ordinate with the demand of the NHS trusts and other employers (Recipient A, see Table 1). Consortia are responsible for creating a demand for nurse education in relation to workforce needs, because as we have seen, it is their duty to collate workforce plans in order to express demand for nurse recruits, and increasingly to commission nurse education from higher education providers. However, this arrangement has been a controversial one, with regular accusations of registered nurse and student nurse recruitment shortages in the popular and academic press (see, for instance, Labour Party Political Broadcast 16/1/97, Nursing Standard 1997a, Naish 1995). Of course, shortages in nursing staff are not a new problem, the issue having arisen periodically throughout the history of nursing (see, for example, Dingwall et al. 1988, Buchan 1997). However, in terms of a quasi-market analysis, if current nurse shortages are genuine, it would suggest that demand for nurse education and workforce demand are not being adequately co-ordinated, and thus by implication, that the quasi-market is not functioning effectively.

Current nurse shortages?

The question of nurse shortages in England is a politically contentious one, and the depiction of this issue differs radically according to the author’s political standpoint. Thus, while the NHS Executive has argued that any shortages are localized or limited to specialist areas, and that numbers of qualified nurses have increased by 2.2% a year on average (EL(96)46, NHS Executive 1996) during the terms of the Conservative governments, Christine Hancock (General Secretary of the Royal College of Nursing) claims we are experiencing the worst nurse shortage for 10 years (reported in Nursing Standard 1997b), and that the NHS is short of 18,000 nurses (Hancock 1997). Below, some of the different types of evidence concerning nurse shortages are discussed and evaluated.

On the one hand, while both the NHS Executive and the Department for Education and Employment acknowledge limited shortages of nurses in some specialist and geographical areas, the latter chose not to declare the nursing profession generally as experiencing shortages (see Nursing Standard 1997a). The NHS Executive (1996) suggests that potential shortage problems will be neutralized by a recent increase in pre-registration entries, and by ‘family friendly’ policies to attract non-working nurses back to work (EL(96)46).

On the other hand, several types of evidence have been used to suggest there are more general nurse shortages. Nursing Times (1997) supplies anecdotal evidence of shortages in its discussion of its nurse poll, which found...
that nearly 80% of nurses reported staff shortages, and most of these said the shortages were putting patients at risk. (However, any response to this evidence must be tentative, as the data are not rigorously analysed; for instance, all the respondents could have come from the same area). Using quantitative workforce evidence to investigate shortages, Seccombe and Smith (1996) demonstrate that vacant and 'permanently open' posts have increased over last few years, while numbers of frozen posts have fallen. 'Vacant posts' refer to unfilled posts which the employer is attempting to fill; 'frozen posts' concern posts for which there is no current funding (for instance, a nurse may have left and has not been replaced); and 'permanently open' posts refer to those posts which have been funded by the Department of Health (DoH), but which employers do not intend to fill. Seccombe and Smith explain that combining these categories for matched samples reveals a 9% growth in total unfilled posts between March 1994 and 1995, and a shift away from frozen posts (indicating that vacancies are being filled as far as possible). This evidence seems hard to dispute, and indicates some shortages in nursing staff.

A further type of evidence concerning shortages and the pressure on existing nurses, suggests that workforce growth is static, while demand is rising (see Buchan 1997). The Department of Health (1996) report showed a whole-time equivalent percentage change of −13.4% in nursing staff from 1985–1995, showing a fall in total hours worked by nurses during this period. Yet Seccombe and Smith (1996) argue that demand for nursing is increasing. This expanded demand, and the lack of nurses to meet it, is demonstrated by the increasing hours nurses are expected to work, and the increased use of agency and bank nurses to fill gaps and top up nurse numbers on a temporary basis. They observe that the sum of excess hours worked by nurses in their study has risen by 39%, and that the number of nurses doing additional bank work doubled in one year from 23% in 1995 to 50% in 1996.

Seccombe and Smith (1996) argue further that the actual situation concerning nurse shortages is worse than their figures on unfilled vacancies suggest, due to demographic factors in the nurse workforce. In terms of the nurse education market, they maintain that their evidence points to a 'growing imbalance between the supply and demand of registered nurses' (Seccombe & Smith 1996 p. 10). This is partly due to the afore-mentioned increased demand for nursing, but is further aggravated by a diminishing supply of newly qualified nurses, the ageing nursing population, the low level of nurse unemployment, and the restrictions on overseas recruitment. Supporting this view, Nursing Standard (1997a) maintains that under 17% of nursing staff were under 30 in 1995/1996, compared to 26% in 1990/1. The RCN Review Body Evidence 1997 (1997) suggests that 25% of the current nursing workforce will have reached retirement age by the year 2002. And responding to the issue of 'family friendly policies' aimed at drawing non-working nurses back into the workforce as a solution to shortages, the RCN Review Body Evidence 1996 (1996) maintains that such solutions are limited. They cite Lader's (1995) study for the NHS Executive to maintain that the 'pool of nurses' not working only numbers few over 20 000 (only about 7% of the employed nursing workforce in the NHS), and that therefore their potential numerical contribution to the workforce is minimal.

A shortage of student nurses?

Any shortages in the current nurse workforce illustrate past planning errors concerning recruitment of pre-registration trainees and retention. However, in order to fill any gaps, and to build up the workforce to meet future health care needs, these issues must be taken into account in current planning of nurse training entry figures. This brings us to the second question of whether or not there are currently insufficient numbers of pre-registration trainees to meet future workforce needs. Any shortages could be due to two factors: current contracting errors, or a lack of students 'signing up' for nursing courses. In 1995, the NHS Executive suggested that to meet future health care needs, an increase in nurse and midwifery recruitment levels would be required (see EL(95)46, NHS Executive 1995b). In 1996 they circulated their calculation that there should be a 14% increase in nurse recruits, and recommended a 12.5% rise in student numbers for 2 years (see EL(96)46, NHS Executive 1996). Currently these recruitment demands are being met, suggesting that there is no lack of students signing up for nursing courses. Figures from English National Board Annual Reports demonstrate that while pre-registration entries in England fell from 1991–1994, they rose from 10 844 in 1994/1995 to 13 924 in 1996/1997, with percentage increases of 11% in 1995/1996, and 15.7% in 1996/1997 (see Table 2). Thus the NHS Executive's demands for increases over 2 years have been met.

In terms of contracting nurse education, however, Naish (1995 p. 6), argues that when planning nurse recruitment figures trusts are failing to notice that many newly qualified nurses are recruited to work in the independent sector; 'a trend which can only increase'. Buchan (1997) points out that, even with recent increased intakes into nurse training, numbers of student nurses being trained are still substantially lower than a decade ago, despite a growth in demand for healthcare. The NHS Executive itself appears to acknowledge problems, as EL(96)46 (NHS Executive 1996) argues that on top of their calculated 14% increase, 'A further substantial increase in training will be needed if future demand for qualified nurses grows'. In response, the then Health Secretary Stephen Dorrell launched a £20.5 million initiative to boost nurse recruitment, and the new Labour government plans to repeat this recruitment
Commissioning of nurse education

Issues and innovations in nursing education

Table 2 Number of pre-registration entries in England

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<tr>
<td>Total</td>
<td>15,202</td>
<td>15,905</td>
<td>15,797</td>
<td>15,452</td>
<td>16,864</td>
<td>15,921</td>
<td>12,464</td>
<td>10,844</td>
<td>12,033</td>
<td>13,924</td>
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campaign (reported in Nursing Standard 1997c). The Labour government is also committed to creating an extra thousand training places for nurses, midwives and therapists in 1998 (Nursing Standard 1997d). It would appear, then, that there is concern about levels of nurse education purchasing, even at government level.

To summarize this discussion, it has been argued that various sources of evidence can be used to demonstrate growing pressure on the existing nurse work-force, and that figures on unfilled nurse vacancies suggest some current shortages in nurse staff. Moreover, evidence strongly suggests that any current shortage is set to become more severe, due to a combination of demographic factors (e.g. the ageing nurse workforce, and the ageing population). This impending shortage has been recognised by the NHS Executive, who have taken pre-emptive steps to counter it. However, arguments persist over the size of the anticipated shortage, and whether or not the NHS Executive’s calculations concerning a 14% increase in pre-registration entrées will be sufficient to neutralize this shortfall.

THE PROCESS OF CREATING DEMAND FOR NURSE STUDENTS WHICH CO-ORDINATES WITH EMPLOYERS’ WORKFORCE NEEDS

This section attempts to provide an over-view of the processes through which consortia go about commissioning nurse education.

Consortia are now responsible for collating and modelling workforce plans (and thus the numbers of nurse training places necessary), and for purchasing nurse education from higher education providers (Stock 1996). They are expected to hold the budget for nurse education from April 1998 (see Snell 1997). The consortia ask the trusts and other purchasers how many new nurses they need, based on a ‘stocks and flow’ model of their workforce. ‘Stocks’ refers to the number of staff in posts required, and ‘flow’ refers to projected factors such as wastage, and staff turnover which are taken into consideration when calculating a figure. Part of consortia responsibility is to provide a planner, and a workforce plan is drawn up according to all employers in the consortium. This is calculated for 5 years ahead. Planning this far ahead can be difficult, and Stock (1996 p. 11) raises concerns that few trusts have ‘reliable historic data upon which to base projections’, and that many trusts lack expertise in workforce planning. The statistical analyses can be at fault for a variety of reasons and at a variety of levels (see Stanwick 1994). Non-trust institutions (e.g. nursing homes, general practitioners (GPs), the private sector) may not be fully represented in consortia, and therefore may not provide full figures, or model effectively. It is possible that some trusts might submit inflated workforce plans thinking that they will win contracts because of this; conversely the perceived idea that the bigger the levy for nurse education the less healthcare employers have to spend on other things may cause trusts to deflate nurse education needs. (The levy is a top-slice of NHS funds which is set aside by the Department of Health for Non-Medical Education and Training). Stock (1996) suggests that competing trusts may not want to divulge information concerning labour demand, as this may implicitly indicate service plans.

The data from the trusts are modelled by the workforce planner, who analyses nurse education in terms such factors as attrition and private sector needs, and adds a figure accounting for these factors to the original workforce need figure. This total figure is returned to the consortia: they examine the data, and sometimes reject or alter some figures.

The figures are then sent to the Regional Education Development Group (REDG): these groups include the chair of each consortium and an independent education adviser, and have an advisory and developmental role. They examine the various plans right across their region, and approve them from a regional perspective. They are able to challenge them, and in this case the REDGs report the problem to their NHS Executive Regional Office, who are responsible for the effectiveness of consortia, and have ‘reserve powers’ (see E(95)27, NHS Executive 1995a) to intervene. The eight regional plans then go to the central NHS Executive who consider all plans based on national need: factors such as the overall growth of the NHS, productivity in the labour market, and trends concerning women workers, are considered as part of this top-down modelling.

The NHS Executive determines the levy for non medical education and training, and has overall responsibility for ensuring an adequate national supply of nurses. Funds have to be applied for by the NHS Executive a year before their advance, and before the Regional Office recruitment demands have been identified. Thus there is not only a 3-year lag in estimates because of the time it takes to train a recruit; but also funding has to be applied for before current assessment has taken place. To cope with this anomaly the NHS Executive has a nationally modelled workforce plan, where productivity and activity analyses are applied to bottom-up systems from a national perspective.
In assessing the Regional Office plans, the NHS Executive may consider financial issues, as well as other factors such as the number of clinical placements available. However, their levies bid can actually go beyond the figure requested by the Regional Offices. For example, it was this NHS Executive modelling which recently led to the securing of an extra 20.5 million pounds to pay for 1300 extra pre-registration entries (DoH Press Release 1997).

Because the consortia remain embryonic they often lack the full workforce figures, and nor are they conducting comprehensive workforce modelling far enough ahead. This concern is reflected in EL(96)46 which 'recognises the need for better integration of medical and non-medical workforce planning' (NHS Executive 1996 p. 2), and the planning of nurse recruitment numbers. Yet the NHS Executive is still accountable to ministers, and has overall responsibility for nurse supply: hence it is in their interest to assist trusts and consortia in 'getting it right' by suggesting the increased figure produced by their models (e.g. 12.5% over the next 2 years, in the case of EL(96)46). Certainly there appears some agreement amongst Regional Office members that 5 years ago mistakes were made concerning recruitment figures, mainly due to the challenges posed by NHS reform in the early 1980s (see also The Guardian 1996). These included an emphasis on 'cutting back', without proper analysis and planning of the workforce (there was no national over-view available at that time); and an optimistic expectation that with the new focus on services in the community, the number of acute hospital beds would reduce, and that therefore fewer nurses would be required (see Dyson 1993) — a prediction which has failed to materialize.

Thus it would appear that demand for nurse students is not being calculated efficiently at employer and consortium level (or at least has not been in the past), due to a lack of information, and therefore central guidance remains necessary. It is apparently hoped that over the coming years consortia will collate more information, and that consequently the NHS Executive will be able to 'let go of their hands' and leave the market to operate on its own (see Snell 1997).

Analysis

Applying a quasi-market analysis to this evidence concerning the commissioning of nurse education by consortia, it would appear that though consortia are commissioning the amount of nurse education apparently identified as demand by healthcare employers, errors have occurred in the past, and are likely to continue to occur, during the supply, collation and modelling of statistical information.

Because of these past errors, it is argued here that the quasi-market is not currently functioning in the manner set out in Table 1. It is contended that, having recognized a significant shortfall in nurse students, the NHS Executive has been involved in guiding nurse education commissioning in a way not depicted in Table 1. They have maintained a guiding influence over decision-making concerning purchasing, and therefore would appear on the demand side (see Table 3).

As such, the quasi-market in nurse education cannot be said to be entirely free from central planning and influence: central control has not been fully devolved in either planning or funding.

Humphreys (1998a) observes the qualitative function of consortia, in that EL(95)27 identifies their ability, via commissioning power, to influence the type of nurse training provided (in this sense, nurse training would reflect the needs of the market). However, he questions the inclination of consortia to make use of this qualitative influence, and suggests that consortia have not spent time devising such strategies due to a lack of incentives. Similarly, Pat Oakley, president of the Association of Healthcare Human Resource Management, who helped pilot consortia, argues that they should be devoting more time to consideration of the type of services needed in the future (and hence the type of workers maintaining these) (see Snell 1997). As consortia are developing rapidly, it may be that this situation has changed since Humphrey's (1996b) research was conducted: further research is necessary to assess any progression in consortia's qualitative influence on nurse education.

If, however, it is the case that neither the qualitative, nor quantitative, aspects of consortia are functioning effectively, it is possible to question the utility of consortia as commissioners of nurse education. As has been noted, consortia have only played a significant part in educational commissioning since 1996; and therefore any imperfections could be attributed to 'teething problems' which might be overcome through experience. Yet it may be that in a changing and growing NHS calculating nurse need will inevitably be problematic (see Worthington 1990); and that holistic, national modelling (such as that carried out at the NHS Executive Headquarters) will prove more accurate than localized bottom-up models. Indeed, this need to retain a 'national overview' has been recognized by the NHS Executive (see Gill Newton, quoted in Snell 1997). If the NHS Executive actually have superior resources with

<table>
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<tr>
<th>Market type</th>
<th>Demand side</th>
<th>Supply side</th>
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<tr>
<td>Nurse education</td>
<td>Advisor, and controller of funds (NHS Executive)</td>
<td>Public, non-profit organizations (universities, etc.)</td>
</tr>
<tr>
<td>quasi-market</td>
<td>Purchaser (consortia)</td>
<td>Recipient A (e.g. NHS trusts)</td>
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<td></td>
<td>Recipient B (students)</td>
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Table 3 The quasi-market in nurse education
which to plan and model workforce figures, and the qualitative function of consortia is not being practised, one could suggest that the arguments for devolved commissioning by consortia are redundant. It can be argued, then, that the 'middle man' should be cut out, as the NHS Executive would make more effective commissioners of nurse education. Trusts are driving the internal market, and are thus directing change, hence it is possible that national modelling by the NHS Executive might miss developments revealed by bottom-up modelling by the trusts. Yet a commissioning system whereby a central body consults healthcare employers (combining top-down and bottom-up modelling) concerning the numbers of nurse trainees does not require consortia (indeed, this is the arrangement in the other UK countries, where the National Offices commission nurse education). In other words, if the qualitative aspect of consortia has not been utilized, and the quantitative aspect is proving inadequate, central commissioning would at least hold the benefit of an accurate quantitative co-ordination of nurse student demand in the nurse education quasi-market.

Hence questions for the future are whether or not the consortia will improve the scope and depth of their workforce analysis and modelling sufficiently to plan accurately without the help of the NHS Executive; whether competing elements amongst consortia will co-operate to produce an accurate picture (see Snell 1997); and whether in any case the procedural costs of consortia can be justified when the NHS Executive have adequate information resources with which to commission nurse education themselves. Without an improvement in the quantitative aspects of commissioning by consortia, it is argued here that consortia may represent a tokenistic product of the philosophy of devolvement.

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Opportunity or Obligation?
Participation in Adult Vocational Training

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ABSTRACT Participation in adult education and training is one of the recurrent themes of educational research, and there has been much speculation about why some adult learners participate whilst others show reluctance. This paper examines key factors influencing participation in in-service job training among a group of nurses employed in the National Health Service and private health care. The study focuses on a group of Enrolled Nurses (ENs) who found themselves in a unique situation, whereby their level of job was being phased out, but 'conversion' course programmes were provided nationally to 'up-skill' nurses to meet the requirements of a higher level of job – first level Registered Nurse (RN). The findings of a national survey identified five categories of employee, based on attitudes to participating in the 'up-skilling' exercise. Both those who participated and those who did not have been categorised according to whether they viewed participation in retraining as an obligation or an opportunity.

Introduction
This paper explores the main attitudes of a group of employees towards participation in in-service job training. Gaining an insight into this subject not only has important implications for supply and demand relationships, but also for the effectiveness of continuing education for adult employees. The availability of data on decisions made by workers about the risks, advantages or disadvantages of undertaking 'up-skilling' or further job training, is limited. This study focuses on a group of nurses who found themselves in a unique situation, whereby their level of job was effectively being phased out, but 'conversion' course programmes were provided nationally to 'up-skill' second level nurses to meet the requirements of a higher level of job.

Participation in adult education and training is one of the recurrent themes of educational research and there has been much speculation about why some adult learners participate readily in continuing education or training, whilst others show reluctance. Houtkoop & Van der Kamp (1992) suggest that there are three recent developments relevant
to participation research. First, continuing education is viewed as a way of raising the economic level of a nation; secondly, there is a belief that demographic and technological developments have made retraining of the labour force essential; and thirdly, retraining of the workforce impacts on the relationship between labour supply and demand.

There has been much interest in the possible rate of return for employers, as well as for individual employees, through participation in continuous education and training. However, there is a paucity of research which studies the attitudes and circumstances in which women participate in continuing education. Huisman (1983, cited in Houtkoop & Van der Kamp, 1992) observed that women often have lower participation in continuing education and job training, although Hopper & Osborn (1975) recognised that there is much untapped potential among women workers. The National Health Service (NHS) as the largest employer of women in Europe (DOH, 1995a) employed 940,000 people in 1994, and accounted for over 5% of total employment in the UK (DOH, 1995b). The NHS relies on attracting and retaining sufficient numbers of well qualified and motivated personnel, and ‘absorbs an extremely large percentage of (...) professional and technical manpower’ (Wilson & Stilwell, 1992, p. 5).

The most significant group of employees, 460,180 in 1992 (DOH, 1995c) is nursing, midwifery, and health visiting, approximately 90% of whom are women (Williams et al, 1991, p. 34). The figures show a move towards a more qualified workforce throughout the 1980s and 1990s. Qualified staff whole time equivalent (wte) increased by 12% over a decade, while unqualified staff wte has decreased by 4% (a ratio of from 233:100 to 271:100; DOH, 1995c).

This paper is based on the findings of a national survey of 600 Enrolled Nurses (ENs) conducted in the summer of 1996. The sample was drawn from the English National Board database, and UNISON and RCN membership. The discussion concentrates on comparisons between converted and unconverted ENs, and examines both quantitative and qualitative data, relating to reasons for converting to first level Registered Nurse (RN), and reasons for remaining an ‘unconverted’ second level Enrolled Nurse. A significant majority of health authorities have provided finance, including payment of course fees and secondment from employment to support second level nurses wishing to complete the conversion course. The aim of the University of Greenwich, School of Post Compulsory Education and Training (PCET) research on Enrolled Nurse conversion, was to examine attitudes to ‘up-skilling’, and to employers’ financial support. The main emphasis of the argument is based on the finding that conversion may be viewed as either an opportunity, or an obligation.
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Research Methodology
The sample comprises nurses working in NHS hospitals and community trusts, as well as bank nurses, practice nurses, and those working in nursing homes. Almost 46 per cent of the 600 nurses contacted, replied to the postal survey. Those targeted were selected to ensure that the sample would vary by geographical location, age and nursing specialization.

The final sample of converted and unconverted ENs is uneven, and includes a higher proportion of converted nurses. The final sample of 275 nurses, included, 184 participants in retraining, 71 non-participants and 20 ENs on conversion courses. More than two-thirds of the sample had participated in the up-skilling exercise or were currently on courses. The analysis is based firstly, on responses to closed questions which were analysed using SPSS (statistical analysis software) and, secondly, open-ended questions which were collated and categorised based on themes emerging from the data. The discussion is supported by written extracts provided by nurses in questionnaires. A full summary of the findings of this research has been reported elsewhere (Hemsley-Brown & Humphreys, 1997a).

Participants in ‘up-skilling’
The findings of the national survey identified five categories of employee, based on attitudes to participating in the ‘up-skilling’ exercise – first, the principal reason given for converting or not converting, and secondly, on the written responses to open-ended questions. Summarised in the following sections are five over-lapping coping strategies employed by participants and potential participants in retraining (95% of whom are women).

Categories of Potential Investors in In-service Training
Opportunity-takers (participants): those who participated and viewed the up-skilling exercise as an opportunity (46%).

Conscripts (participants): those who participated and viewed the up-skilling exercise as an obligation (25%).

Opportunity-seekers (non-participants): those who were prevented from participating and viewed the ‘up-skilling’ exercise an opportunity they were denied (7%).

Conscripts (non-participants): those who were not participating and viewed ‘up-skilling’ as an unwelcome obligation they were avoiding (5%).

Abstainers (non-participants): those who were not participating, (in many cases temporarily), but viewed the ‘up-skilling’ exercise as an
opportunity (15%). Figures are rounded and some participants did not respond to the relevant questions.

First, those who participated have been categorised as 'opportunity-takers' and 'conscripts'. Many nurses acknowledged that 'conversion' was both an opportunity, but also an obligation, because initial training for their existing job had been phased out. They were, therefore, aware of the potential disadvantages of remaining a second level nurse, but also recognised the career advantages of taking up the opportunity to gain first level status. Recruits to education and training are 'investors', and are only willing to participate if the rate of return is perceived to be justified. That is, it must be clear that training will result in an increase in salary, or improved job prospects, working conditions, promotion or job security. Those who willingly participated in the conversion programme, to 'up-skill' confirmed that these factors were important influences on their decision.

**Participating 'Opportunity-takers'**

Those who viewed conversion as an opportunity and participated, were the largest group in this study. Financial support from an employer, including secondment from the workplace, provided a considerable incentive to employees to participate in retraining. Over 90% of those who participated in the 'conversion' course programme, were supported financially by their employers and were paid by their employers during retraining. Ten per cent of those who participated, had paid part or all of the costs of their retraining. 'Opportunity-takers' were those respondents who had voluntarily participated in the 'up-skilling' programme, and who viewed employer supported and funded retraining as an opportunity to enhance their career in nursing. One 'converted' nurse commented that having the opportunity to stay in her present post and have paid study leave, 'greatly influenced the decision to convert'.

Comments made by respondents who viewed retraining as an opportunity, may be groups under five headings: first, self-improvement; secondly, career advancement; thirdly, flexibility; fourthly, confidence and security; and finally, as a new challenge. Many nurses who had completed the programme, found renewed enthusiasm for their work and were encouraged by their own achievements. One nurse observed that the most important factor was:

*The self satisfaction of realising one is never too old to learn. Positive attitudes are extremely important and I knew there was lots to learn.*

Participants also commented on the notion of 'proving something to themselves'. For example, two respondents said that they wanted to 'prove' that they were 'capable' of advancing in their careers. Another nurse expressed the idea that gaining a higher qualification was 'the
fulfilment of a long held ambition'. There were also respondents in this
category, who believed that they had always been capable of gaining
higher qualifications, but had never been given the chance.

_I realised having achieved first level status that I had been wrongly
steered towards second level nursing. I was more than capable of
studying and achieving and as an EN I was constantly reminded that I
was never good enough to be a 'real' nurse._

In various ways these participants were able to prove something to
themselves, namely that they were given the opportunity to gain higher
qualifications and work in a job which previously had seemed out of their
reach. The notion that a 'real nurse' is a Registered (first level) Nurse was
emphasised, and confirms that as second level nurses many experienced
a feeling of 'inferiority', and were treated as 'second class individuals', as
well as second level nurses.

Secondly, there were many respondents who pointed out that the
retraining programme opened up a whole new career with a clearly
defined structure and opportunities for promotion, which they had been
denied as second level nurses. One nurse commented that, "I was unable
as a second level nurse to gain access onto many of the continuing nurse
education programmes." This indicates that one of the benefits of
continuing education is that it enables an individual to get started on the
road to further and higher education and training. Further confirmation is
provided by a respondent who said that:

_I am now halfway through a degree course which six years ago
seemed a far away dream. I [originally] only did my EN training
because I did not have the qualifications to be an RN._

Many of the participants were not considered sufficiently academically
qualified to become registered nurses when they first entered training
and three of those who responded had failed their first level training
many years ago. However, after a number of years working in nursing and
with accumulated experience and maturity, a high percentage of second
level nurses were quite capable of achieving first level status after a
period of retraining.

Thirdly, the notion of 'flexibility' in a career is also mentioned and
one EN from Hampshire pointed out that flexibility would mean that, "I
can get another job whenever I want to. There's no jobs for ENs except in
mental health and geriatrics." The notion of flexibility was confirmed by a
nurse who argued that the reason she converted was for, "Flexibility –
not to stick in one job. I have the qualification now to apply for jobs
without being told 'you're only an SEN'."

Fourthly, there were a number of respondents who gained
considerable confidence and security from undertaking a period of
retraining. This was confirmed by one respondent who said that, "Since
converting my confidence has been given a much needed boost”. Another wished to encourage “all ENs to convert” and said that “the whole experience of the course was enlightening. (…) We have to move forward.”

The flexibility of some conversion course programmes offered to enrolled nurses enabled many to ‘up-skill’ with virtually no financial risks. One EN explained that:

*I was the main wage earner at the time and I needed to be RGN for more job security. Also I wished I had RGN training instead of EN, but I did a part-time course for 104 weeks which suited me at that time.*

For many women in this study, job security and security of income were very important and, therefore, they were unable to take a financial risk in order to undertake the necessary training. There were no comments which suggested that female employees were working for ‘extra’ money. Both income and career were important and half of all respondents were the main wage earner.

Finally, the conversion programme was also viewed as a new challenge by some enrolled nurses. One EN admitted:

*I have always enjoyed study of any kind and so the challenge spurred me on. Knowledge can be a very powerful tool. My personal development during the conversion has been outstanding.*

Participating opportunity-takers, therefore, were those ENs who willingly undertook the conversion course, or the ‘up-skilling’ exercise and viewed the experience as essentially a positive career move. Many were able to emphasise the positive aspects of retraining towards a new career in nursing and gained confidence, self-esteem and job satisfaction. Although many had gained higher grading and salary from their retraining they did not emphasise this aspect as the main reason for undertaking the additional training. The majority of ‘opportunity-takers’ were those who were keen to improve their career prospects and widen their career opportunities, especially because they were aware that the career prospects of second level nurses were very limited. This category also included nurses who were fulfilling a dream of becoming a higher level nurse, which they had previously been denied. Financial security was important and job security was the factor which made ‘up-skilling’ a risk unless employers provided the necessary support. Although 95% of respondents were female, whether single or married (and whether or not they were caring for children) investment in their careers with only a low risk to their job security was a vital element in the decision to participate in further training. Job security and fear of the future and concern about the phasing out of the second level nurse resulted in some participants, however, feeling that they were less than willing ‘conscripts’ in the ‘conversion’ programme.
Participating 'Conscripts'

Early press coverage of the setting up of conversion course programmes highlighted the anxieties of many nurses all over the country who were unable to gain a place on a course. The problem appeared to be the small number of places, whether funded or not, on a small number of courses for the large number of individuals anxious to participate (see Chudley, 1988; Cottingham, 1988; Fardell, 1989; Boland, 1989). However, as more courses were set up, offering greater flexibility, open learning and opportunities for part-time study, the number of enrolled nurses participating in the 'up-skilling' exercise rapidly increased (Hemsley-Brown & Humphreys, 1996). The 'race' to convert gathered speed during the early 1990s, which appeared to put pressure on those who had been uncertain about whether to participate. One respondent said that, as more ENs participated she felt more pressure, and that she felt 'more underrated as more ENs converted.' The main factor which identifies participating 'conscripts' is that they felt they 'had no choice', and that they were aware of what they described as 'pressure from management'. The comments made by participating 'conscripts' are related to, first, pay and grading; secondly, being 'left behind'; thirdly, fear of the future; fourthly, being downgraded; and finally, employer funding and management 'pressure'.

There were some 'conscripted' ENs responding to the survey, who had converted because they were anxious to secure a better salary and argued that they had no choice but to convert if they wanted to keep their post. An EN from Gateshead said that, "I could not get higher than a C grade as an EN". There were a small number of ENs who believed that they should be awarded a higher grade, (E grade) for the job they were already doing and had converted in an attempt to gain a higher grade for the same post. This is explained by one rather frustrated EN who wrote:

Now it is two years since I converted to RN. I have not been rewarded with an 'E' grade. 'E' grade is given to new applicants only in an attempt to attract them. I have a wide range of experience and I strongly believe that I deserve a higher grade.

The problem of securing a higher grade in the same post, after converting, is explained by a nurse who said that, "There are too many ENs who after converting are kept on their previous grade as it's the only post available. Despite being RGNs." The quantitative data, however, shows that only about 50% of those who stay in the same post are awarded a higher grading, simply for converting. This situation has led some ENs to feel frustrated, that they were obliged to convert by their employers, but they have not been awarded any salary advantage from the up-skilling. Research suggests that enrolled nurses have frequently
described themselves as 'abused' in their existing role (United Kingdom Central Council [UKCC], 1986), because they argued that they were already doing the work of a first level nurse without either the salary or the status.

Secondly, anticipated job insecurity encouraged a number of ENs to do the conversion course, implying that they were unlikely to have re-trained for a higher skill level if their job had remained secure. When asked to provide a single influence on their decision to convert, a high proportion of nurses gave 'job security' (19.2%) as their main reason. They claimed that they had little option but to 'convert' if they wanted to continue to be employed. One EN said that things she had heard, "implied that there would be no choice of jobs if I stayed as an EN. I was worried about career prospects." This view is explained by one EN who had a fear of being "totally unimportant and of being left behind. No career prospects at all as an EN." One EN was especially angry about the changes, although she had completed the additional training. She claimed, "I am converting out of necessity."

For those who were still young and with years of working life ahead of them, the fear of the future was greater. One respondent said she converted because of "fear of what was going to happen to ENs. I still have 30 years working life left." There were nurses who were aware that their chance of gaining another post would be very limited if they remained in their current job which was being phased out.

Nurses were concerned about their longer term security and felt they would be trapped if they remained in a job which was disappearing, even though there was still a demand for people to carry out work at this level. Significantly, however, work at this skill level was increasingly being carried out by un-qualified or lower qualified staff (Workman, 1996, p. 615). These fears did seem to have persuaded many nurses to convert now, rather than later - even though the United Kingdom Central Council (UKCC) provided re-assurance about the continuation of the conversion course programme (Hemsley-Brown & Humphreys, 1997b). One EN explained:

_I was, however, fearful for our future. I was anxious to convert before NHS trusts withdrew funding. This is now being phased in and ENs converting have to do the course in their own time. The next phase will be withdrawing the funds._

The main fear was related to funding being withdrawn, rather than a fear of places on courses no longer being available in the future. Because employers had funded 'up-skilling', however, employees felt that the choice about when they choose to participate was taken away from them and this also caused anxiety.

The fear which many ENs expressed about their future also included comments about the possibility of losing status as a 'nurse' and being
down-graded. This down-grading, included fear that they might be considered a low qualified low status assistant and that their nursing qualification would effectively no longer be recognised. One EN simply said that she "thought that ENs would be demoted, if they didn't convert." These comments implied that many nurses felt under obligation to convert if they wished to remain nurses, and to have their qualification recognised. The obligation to up-skill became more urgent because these nurses felt more undervalued as more nurses participated in conversion.

There was some criticism of management's or employers' involvement in the conversion exercise. The funding which was provided for ENs to convert and the increasing number of places made available on courses seemed to have put unwelcome pressures on many nurses to convert against their will. Many nurses who had converted, and who were funded by their employers expressed anger. One EN believed she spoke for others when she wrote:

As an ex-enrolled nurse I, together with many others of my colleagues feel pressured by employers to convert and having subjected myself to a long period of extra study resulting in stress and tension, I feel it is grossly unfair having attained the qualification and then later to be informed there is no extra financial gain.

Those nurses who felt under obligation to convert and felt that they virtually had no choice, were more anxious about gaining a higher grading and pay from the conversion, than those categorised as 'opportunity-takers'. Another EN implied that colleagues had been 'put under undue pressure', and she argued that they should be allowed to remain at the lower skill level if they chose to.

It seems, therefore, that some nurses, because they were unwilling 'conscripts', expected their employer to carry the whole burden of the 'up-skilling', including paying them a higher salary for doing the same job. In some cases, nurses argued that they would not expect to be better nurses by undergoing the up-skilling programme. The main incentive to up-skill for this group was to regain job security and to regain status as a nurse, rather than to gain additional skills to enable them to carry out a more demanding role or to invest in their career in nursing. The employer was blamed for the anxiety about job security and threats to status and was, therefore, expected to compensate the employee. However, many employees would not have been prepared to undertake up-skilling at all, if their jobs had remained secure.

Enrolled nurses were already feeling under-valued by the profession because of their 'second level' status, and so anger soon emerged as a response to their impossible situation. They felt 'trapped' and conversion was the only way out. Those who felt under obligation to convert were more likely to be concerned about the financial gains promised by gaining
a higher qualification and for those who remained in the same post this had not been fulfilled.

A third of 'converted' nurses were categorised as 'conscripts' (34%). However, although those who participated in conversion have been categorised as opportunity-takers and conscripts, there were nurses who had mixed feelings about their experience, and it would be misleading to treat the categories as having strict boundaries. Some respondents acknowledged that they had gained personally and could expect enhanced career prospects through gaining a higher qualification, but they also argued that they had little choice and the phasing out of the second level nurse had caused anxiety and job insecurity.

Non-participants in 'Up-skilling'
Although only just over a quarter (26%) of those who responded to the survey were unconverted nurses, many wrote forceful arguments in response to the questions providing them with a chance to explain their situation. The comments although relating to a relatively small number of people compared with converted ENs, expressed anger and frustration in many cases, as well as disillusionment with their predicament. There were three categories of non-participants. Those who had 'abstained', but who viewed conversion as an opportunity which was not appropriate for them at this stage in their life; those who felt under pressure to convert, but were unwilling conscripts, and did not intend to participate; and finally those who could see the advantages of taking up the opportunity, but had been denied the chance to participate. Those who had not participated tended to have one reason why they had not converted and, therefore, non-participants were firmly in one group with little overlap.

Non-participating 'Opportunity-seekers'
Respondents in this category were prevented from participating because of 'institutional barriers' (Houtkoop & Van der Kamp, 1992, p. 537) (approximately 24% of unconverted ENs). Virtually all those respondents who are categorised as non-participating opportunity-seekers are those who were unable to gain the support, funding or backing from their employer to participate in the programme. There were a number of different factors which contributed to this. First, geographical location; secondly, lack of 'sponsorship' from managers; and thirdly, difficulties gaining a place on a course; and finally, financial considerations. These factors are interrelated in many cases, because the problem of gaining a place on a course is frequently linked directly to securing the necessary funding from an employer for that place.

Although the sample in this present study was small (275 respondents, of whom 71 were unconverted), there were eight nurses out
of 10 from Scotland who were unable to secure a place on a course through lack of funding. In English counties where these problems had occurred, those who could not gain funding were from different counties. One nurse living in Scotland said that:

*I would like to convert, but I cannot afford to live on a grant. I have tried to gain a place on an open learning conversion course but the trust will only pay half and I cannot afford to pay the other half. (Single nurse, living in Lanarkshire)*

Another EN said that she could not get any backing from the Glasgow Health Authority and that she could not get a place because of lack of money for conversion. A nurse in Aberdeen also commented on the problem of gaining funding.

*I wish to undertake conversion with also staying in full time employment. This is not possible in my geographical area (Aberdeen). I am currently undertaking a BA degree in Psychology with only one year to complete.*

The lack of funding in Scotland was a source of much frustration for nurses working in this region. One nurse working in theatre nursing in Scotland, said that she had been unable to convert because, 'management tell you it's hard to let you go'.

Nurses who were working in particular specialisms, found additional difficulties, especially if they wished to become a Registered General Nurse (RGN). "I would still very much like to convert, but only if I can do RGN and not my specialism." There were also nurses who said that they had been trying to convert since the beginning and others who said that they had not been given the opportunity to go on a course by their employers. Those who claimed that they had been unable to get a place on a course were also expecting to gain the support of their employers to provide funding. One 56-year-old nurse from Kent felt very angry that she had been unable to convert, and explained, "I did not decide not to convert. It seems to have been decided for me. I would not convert now even if they asked me."

Those who explained that financial considerations had affected their situation were not only affected by lack of funding from employers, but also by their own circumstances. One EN argued that, money should be provided for 'all ENs to convert', and ENs 'should not have to pay for their own conversion.'

Those who were working outside the NHS also experienced difficulty in converting because as one EN explained, she was 'working for a nurse bank', and had, therefore, been 'unable to convert yet'. Another nurse wrote,
I work in the community in a care home — private, and I can’t afford to lose a wage and cannot finance myself — i.e. the cost of the conversion course.

Written comments suggested that there were a few nurses who were expecting to pay towards their conversion. One nurse said that she had been unable to convert because of, "lack of money, I am the breadwinner in the household." It is clear that whether ‘conversion’ is possible when one is the main wage earner depends on current circumstances and the risks involved. One nurse argued that she had converted because she was the main wage earner, but another argued that she could not convert, because she was the main wage earner. For those who had been unable to convert, however, on the whole, financial support and management sponsorship were at the root of the difficulties, and these individuals had been unable to find all or part of the programme themselves. For some of these individuals this situation was very frustrating, and much of the anger was directed at employers and managers.

Non-participating ‘Conscripts’

Respondents in this group were prevented from participating because of ‘dispositional barriers’ (Houtkoop & Van der Kamp, 1992, p. 537). They represent about 19% of unconverted ENs, in this study. Those who were determined not to participate in conversion were very disillusioned with changes in the profession, and were anxious to express their views about the unwelcome changes. They form the smallest group of non-participants, and of all those surveyed (5%), but they provided rich written comment on the situation. On the whole, non-participating conscripts felt that they were under pressure to convert, but were against the idea. They believed that further training would not make them better nurses and they felt under-valued now that so many nurses had up-skilled. They were especially hostile about administrative work and mentioned loyalty and length of service to support their decision to remain unconverted.

The main factors which identify non-participating ‘conscripts’ are first, a belief that further training is ‘irrelevant to nursing’; secondly, a preference for ‘bedside nursing’; thirdly, loyalty and length of service; and finally, a belief that there is nothing to be gained from ‘converting’.

There were a number of comments made by unconverted ENs which implied that additional training was irrelevant to the job they were doing and therefore unnecessary. Two nurses who dropped out of courses expressed this view and used these arguments as a way of rationalising, and coming to terms with their failure.

What I have learnt during my attempted conversion is of purely academic purpose and nothing to do with nursing in the field I work.
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(learning difficulties). Had I passed, the information obtained would have been no use to me at all.

The belief that undergoing additional training was a waste of time was also mentioned and it was clear that some nurses did not believe that they needed any further training to continue in the same job.

I do feel the conversion is a waste of precious time having talked to the older generation who have converted. It would be two years of worry from my precious life! I have not enough time or motivation to do further training for a job I've been doing for years.

There were a number of comments and reactions against the changes in nursing and reminiscences about the old system. One nurse argued that:

I am not convinced that patients get better care now. I have found nurses are less conscientious. The old ward sister worked well. Matron was the captain of the ship.

Those who commented that additional training was irrelevant or a waste of time also mentioned that the training would not make them a better nurse.

I feel it will not make me a better nurse. I need hands on care for my patients. I don't want to pen push all day.

Several nurses mentioned 'pen-pushing' specifically, as a way of describing the work of a first level nurse. They were unwilling to take on a more administrative or management role and viewed first level nurses not as bedside nurses like themselves, but as administrators. The work of a 'bedside nurse' which ENs believed was their particular role, was mentioned by several nurses who preferred to remain at the lower skill level.

In order to support a decision to remain at the lower skill level many nurses mentioned loyalty and length of service. One example of this is provided by an EN with 22 years experience in one post. She also makes it clear that she feels under great pressure to convert.

At 50 years old and the pressure of - 'if you do not convert there is no job' - do not help. I am happy how I am. I requested my colleagues to leave me alone. We are the old school. We are the workers - loyal to the ward - 22 years in dialysis. [Underlining is in the original]

Another EN implied that by not converting she was remaining loyal to her patients, and to her colleagues, and was not in favour of all the changes in nursing. "I have not converted because of the staffing levels, loyalty and consideration for clients and colleagues."

Many nurses with considerable experience, especially in one specialism, argued that they should not have to convert, but should be awarded the higher first level status without any further training. Some nurses thought that, "ENs who trained in a specialty should have been..."
upgraded automatically," and another explains that, "we should be given our first level without conversion because of our wide experience."

Although there were some ENs who resented having to complete additional training there was also one nurse who said, "I still believe that ENs should not be automatically converted without further training, extra skills are needed." However, the view among many of those who remained unconverted was that they should not be pressurised into undertaking the course, although many were also dissatisfied with their current situation.

Some ENs expressed the view that they could see no positive reasons for converting. Within this group there were nurses who had already been awarded the highest grade, (E grade), although they were still second level. One EN argued, "I cannot believe that I would gain anything, e.g. promotion, job satisfaction from being a first level registered nurse." Another claimed that her experience should count for more than the course and, therefore, she would remain a second level nurse.

I want to look after patients to the best of my ability – which I feel is on a par if not better than many RNs I've worked with. Fourteen years experience surely counts for more than the course offers.

A 'spinal' nurse from Buckinghamshire, said, "I am happy to be an EN and in the area of nursing I am in I am treated as an equal with an RN." Another pointed out that, "I love my job and being an EN, ... I am better at doing the practical work. We are not all high flyers."

There was a strong resistance to change among this group of nurses. Statistical evidence showed that the longer a nurse had remained in the same job the less likely they were to convert (Hemsley-Brown & Humphreys, 1997a). They were unable to accept that they would gain anything from the retraining programme to become a higher level of nurse, either because they believed the training was irrelevant to nursing and devalued their role as a second level nurse or because they had a preference for their existing role.

Non-participant 'Abstainers'

This group were prevented from converting through their personal circumstances, or through 'situational barriers' (Houtkoop & Van der Kamp, 1992, p. 537). They account for 56% of non-participants and form the largest group of unconverted ENs. The group identified as 'abstainers' were not resistant to change, or concerned about lack of funding, lack of places or management attitudes. Reasons provided by 'abstainers' included, first, age – especially when close to retirement; secondly, child care; thirdly, lack of confidence; fourthly, health reasons; and finally, academic qualifications.
Those who gave age as their reason for not participating in further training were typically over 50 years of age, but this is not necessarily a barrier to up-skilling and is dependent upon personal perspective. One EN of 44 for example, argued:

*I feel I am at the back end of my career and the cost isn't worth the result. I doubt if I could do my work more efficiently by converting.*

However, another EN, who had just completed conversion, triumphantly wrote:

*I have proved that one is never too old to learn. I started the conversion course at 58 years and qualified 2 months before my 60th birthday! I learnt so much I am still putting it to use.*

It is clear, nevertheless that for some ENs, especially those who are part-time, that undertaking a course of further study when approaching retirement was not viewed as worthwhile. It would be misleading to assume that all those over 50 fell this way, however.

Child care was also provided as a reason for not participating in conversion, although for most nurses in this category, it is a temporary constraint. Added to the problem of simply deciding to care for children as a priority, is the shortage of time available to concentrate on further study. One EN explained, 'I have two very small children who take up a lot of my time, and I feel I would not able to give the time needed to convert.' One nurse also explained that she had put 'having a family' at the top of her list, and therefore she would be unable to convert for the time being. There was no statistical correlation between the decision to convert and the ages or number of children being cared for. Those who were prevented from undertaking a course of further training, because they were caring for children, were making the care of their children a priority at this stage in their lives.

A small number of nurses remarked that they had not participated in the conversion programme because they 'lacked confidence'. Confidence, may be connected either with academic study, a long period of child-rearing, part-time working, or simply motivation. One nurse admitted, "I had four children when the phasing out started and now I have very little confidence in coping with the learning side of it." Another claimed that:

*being part time for the last 11 years has reduced my confidence a lot. (...) I would be unable to sit and relax or work at home. I am not motivated.*

Worry about coping with academic study was mentioned by a number of nurses, not necessarily only those with no previous academic qualifications. Some nurses were aware that they had found difficulty in the past with written work. Two EN respondents admitted that they had
failed written nursing examinations in the past and expressed fear of further failure.

*Worried I may well fail again. I took my SRN twice and failed. No-one wishes to hammer their confidence into the ground.*

Anxiety about the written work (including the problem of working in a second language) was a real barrier to a small number of ENs, and one respondent admitted:

*I am worried whether I am up to the learning side of it. I am worried about the huge emphasis on education and worried about the hands on experience in other areas.*

Amongst those who claimed that they had not converted because of the academic components of re-training, a small number of nurses claimed that, “I don’t like studying, I am better at practical work.” Statistical evidence showed that the more academic qualifications nurses had achieved, the more likely they were to participate in further training. Those with no qualifications were less likely to participate (Hemsley-Brown & Humphreys, 1997a).

Finally, there were three nurses who explained that they were prevented from participating in the conversion course because of health and personal problems. Health problems, however, did not necessarily prevent someone from participating in further education generally, as this EN explained:

*I suffered a back problem 4 years ago. Decided to take alternative qualifications in case I was unable to cope with nursing. I have obtained HND in applied biology and I am currently studying for a BSc. in Biomedical Science, for which I have obtained a mandatory grant.*

There were also women in this study who were temporarily prevented from participating because of a bereavement or an illness in the family, and one EN was hard of hearing and explained that this would make further training difficult for her.

**Discussion**

Facilitating up-skilling is considered by many second level nurse employees to be a welcome opportunity which released them from a frustrating predicament. However, it would be too simplistic to assume that providing the necessary funding will encourage all employees to participate willingly in further education and training – even when their level of job is being phased out. It is also, however, too simplistic to assume that the factors which prevent adults from participating are ‘situational barriers’, such as child care, age or personal reasons. The provision of funding and support from employers for up-skilling, especially when the jobs of potential participants are becoming obsolete,
PARTICIPATION IN ADULT VOCATIONAL TRAINING affects the decision to participate in two distinct ways. Potential participants tended to divide themselves into 'opportunity-takers/seekers' and 'conscripts' – either they were anxious to participate, seeking funding at the best opportunity, or they felt under undue pressure to participate and blamed others for their unwelcome predicament. Although providing adequate funding is vital for those who are anxious to up-skill, this situation also causes a minority to resent the obligation to undertake additional training, become hostile about change and about the pressure to participate. In addition, many of those who did participate did so primarily because they were anxious that their own job might be insecure. Nurses working in more secure posts, (many of whom were over 45) were less willing to participate in up-skilling, and viewed re-training as a criticism of their existing performance.

Facilitating access to 'up-skill' tended to provoke those who had not yet participated to feel more threatened and under-valued in their current job. Some of these individuals became more resolute in their views and more critical of change, although the pressure of up-skill is not necessarily the cause of the resentment, it may simply provide further reasons to feel dissatisfied in an already unsatisfactory situation. The employer expects to get a return on the up-skilling exercise by gaining more highly skilled workers who not only justify a higher grade, but are able to take on more responsible roles and more highly skilled work. Many nurses, however, took the view that they were already doing a more demanding job at the higher skill level and should have been retrospectively rewarded, or alternatively, that they did not wish to work at a higher level.

The comments made by those who had participated voluntarily, however, and who were able to secure the funding were very positive and it was clear that this group of individuals felt freshly motivated and optimistic about their new careers. Their sense of achievement was clearly expressed by many respondents, even though many were initially sceptical about the benefits of additional training. Financial gain, however, was not given as the main motivation of those who participated willingly, they were significantly more likely to claim that their reason for converting was to improve and widen their career prospects (Hemsley-Brown & Humphreys, 1997a).

Employers, in particular managers of very large organisations such as the NHS, were the object of criticism by three groups of nurses:

- those who had been 'conscripted' into conversion and felt obliged to participate;
- those who were being denied an opportunity to convert;
- non-participants who felt obliged to convert, but who were resisting.

Employers and managers were criticised by one group of nurses or another whether they facilitated access or restricted access. Financially
supporting large numbers of participants was perceived by some nurses as undue pressure upon those who were reluctant to up-skill and wished to remain on the lower skill level. Those who preferred to remain at the lower level also began to feel insecure and treated the up-skilling programme as a criticism of the work they were currently doing. Without substantial funding and secondment, however, most employees would not have participated in additional training because the short term risk financially and to job security was too great. It is clear from the research findings that few nurses would have funded their own conversion and resigned from their secure job in order to study. Restricting participation, however, by not providing adequate funding to facilitate immediate up-skilling also caused much anger and frustration among those who were anxious to take up the opportunity. An unavoidable effect of providing funding and support for up-skilled seemed, therefore, to be continuing hostility among a group of employees who were already frustrated by their working situation.

The timing of the up-skilling programme was also the cause of much frustration, whether the exercise was carried out rapidly or whether the courses were set up gradually over a longer period. In the 1980s the shortage of places on courses was criticised regularly in the nursing press and nurses all over the country were becoming anxious about the lack of opportunities to convert to first level, as the only way out of their predicament. When the pace quickened and more courses were set up to facilitate access to almost five times as many nurses, those who had not yet converted became anxious to participate before the funding ceased. Both situations, it seems, caused anger among one group of nurses or another.

**Conclusion**

A balance of supply and demand, both of funded support and course provision is, therefore, a very delicate, but crucial balance for employers to achieve, particularly because sometimes the loudest voices are not necessarily representative of the majority of views. In the case of enrolled nurses causes of anxiety were, first, the short period during which initial training at the lower skill level was to be phased out and, secondly, the need to estimate the risk to job security of participating in the additional training. Finally, the lack of opportunities for in-service training offered to second level nurses in the past, prior to Project 2000 (UKCC, 1986) and the frustration of being 'second class' as well as second level, also contributed towards the popularity of the conversion course programme when it was first launched.
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Devolution or centralization? Differences in the development of nurse education commissioning policy among the UK nations

Becky Francis and John Humphreys

An overview of the different systems for the commissioning of nurse education in the various UK countries is contextualized in the policy concerns of devolvement and marketization driven by Government Working Papers 9 and 10. The different systems for commissioning nurse education in the various UK countries are described, with a particular focus on the English consortia system and its level of efficiency. It is argued that while the mechanism of consortia is being used to marketize nurse education commissioning in England, in the other three nations the commissioning process has actually become more centralized. This centralization is contrary to the policy of devolvement, yet it is suggested here that the consortia mechanism adopted in England has not been followed in the other UK nations, as it has not yet proved an independently efficient method of commissioning.

The British policy background to nurse education commissioning

In the late 1980s a series of government White Papers were published with dramatic consequences for the British National Health Service (NHS). Working Paper 9, Working for Patients was implemented through the Conservative Government’s National Health Service and Community Care Act (1990). This intended to provide greater efficiency in the NHS by introducing an ‘internal market’ in health care, via the creation of a purchaser/provider split among former health care providers such as district health authorities (Holiday 1995, Klein 1995). This raised important issues concerning the funding and commissioning of nurse education. Previously the funds of nurse training had been largely conflated with the funds for health care delivery. However, if this arrangement was retained in an internal market, the service providers might seek to cut the costs and level of nurse education in order to make their prices more competitive in the short-term (Humphreys 1996). A further white paper was commissioned in order to investigate and recommend a method of educational funding whereby these funds would be separated from health service monies.

Working Paper 10 reviewed the then arrangements for nurse education in light of developing NHS reforms. It advocated greater competition and marketization of nurse education, and for employers to have greater control over nurse education. Devolvement of responsibility for education commissioning to employers was foisted as a way to maintain production of a newly qualified workforce responsive to employer and workplace needs (Burke 1995, Humphreys 1996). Working Paper 10 was adopted as policy for England by the government in early 1991. The other three countries had comparable policy papers (e.g. Towards 2000 in Wales, 1993). In all four UK countries these papers drove policy concerning
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Nurse education commissioning to focus on employer involvement, and competition (in the belief that greater competition will lead to greater efficiency [Working Paper 10 1989]). The funding for nurse education was channelled to the Department of Health, meaning that this department was purchasing education from higher education providers.

Since the election of the Labour Government in 1997, the emphasis on free-market philosophy in the NHS has been reduced, and Health Secretary Dobson's white paper The New NHS – Modern and Dependable (1997) seeks to abolish general practitioner (GP) fundholding. The internal market in health care will consequently end (Nursing Times 1997, Health Service Journal 1997), and GP fundholding will be replaced by 'primary care groups' (The Guardian 1997). There seems consensus on the part of the Labour Government policy-makers, as well as many academics, professionals and managers, that the internal market did not produce the efficiency gains expected, but actually increased inequity and inefficiency (Holiday 1995, Cortis 1997, The Guardian 1997). However, this dismantling of the internal market has not applied to the quasi-market in English nurse education.

Nurses comprise the largest professional workforce group in the health service, and the supply of adequate numbers of nurses is a controversial political issue: shortages of nurses concern the public and imply that the government is uncaring or incompetent (Francis & Humphreys, forthcoming). Pre-registration nurse education supplies newly qualified nurses to the workforce. Hence, the commissioning of nurse education and 'getting the numbers right' are critical political issues. Nurse education commissioning was previously performed by the various Health Authorities and statutory nursing bodies (National Boards) in the different countries; each was funded by the government. However, this situation has altered since the Conservative Government NHS reforms, and in Scotland, Wales, and England the function of the national boards has been reduced to setting and monitoring the quality of nurse education establishments. At the time of writing, the National Board of Northern Ireland is still funded to commission nurse education by the Department of Health and Social Security (DHSS) in Northern Ireland but this is set to change, following the path of Scotland and Wales where funding is directly provided by government offices to nurse education institutions. Before v discuss the possible reasons for these differences in approach to commissioning, the current systems of commissioning in the different UK nations are now briefly explained and compared.

Outline of the systems in the different UK countries

England

By 1992 the elements of a market in nurse education were in place in England, with supply being located in higher education, providing to the demand of regional health authorities (RHAs) and NHS trusts (Humphreys 1996). In 1993 the RHAs were replaced by eight regional offices of an NHS Executive, and a new framework for nurse education was arranged, whereby student nurse requirements would be calculated and purchased by consortia. Consortia are local groups of representatives from health care employers; the idea being that by involving employers in education purchasing, central responsibility is devolved, and employers have more power over the number of nurses trained and the type of training they receive. Consortia began to take responsibility for educational contracting from April 1996, and many will be given full purchasing responsibility in April 1998 (EL(97)30). The funds for this come from a non-medical education and training top-slice from the health service recipients of trained nurses, which is controlled by the NHS Executive, and bid for by the consortia. While the internal market in health care is currently being dismantled, the market in nurse education remains intact. Indes with the planned devolution of direct purchasing power to consortia in April 1998, and the inclusion of nursing degrees in their remit (The Times Higher Educational Supplement 1997), it would appear that the position and power of consortia is being considerably strengthened.

Hence consortia are currently responsible for collating and modelling workforce plans (and numbers of nurse training places necessary), and for purchasing nurse education from higher education providers. Part of consortia responsibility is to provide a person to plan...
manpower needs, and a workforce plan is drawn up according to the needs of all the employers in the consortium. This is calculated for 5 years ahead. These figures are channelled up through the NHS Executive Regional Offices, who consider consortia plans from a regional perspective, and then send their regional plan to the central NHS Executive. The NHS Executive consider all plans based on national need: the overall growth of the NHS, productivity in the labour market, and trends concerning women workers. For a more detailed discussion of these processes, see Francis and Humphreys, forthcoming.

The NHS Executive has overall responsibility for ensuring an adequate national supply of nurses. In assessing the regional office plans, financial issues may be considered; however, their bid for DoH funds can actually go beyond the figure requested by the regional offices, particularly as the NHS Executive is modelling the workforce 2 years ahead, rather than 1 year ahead as with the regional offices. For example, it was reportedly this NHS Executive modelling which recently led to the securing of an extra £20.5 million to pay for 1300 extra nurse recruits (DoH Press Release 1997).

Scotland

Funding for nurse training is given to the Scottish Health Boards by the Scottish Office. This money is earmarked for training so that the Boards are unable to use it for anything else. Thus, the NHS has purchaser contracts with educational institutions as providers to supply nursing and midwifery education (Scottish Office 1995). Prior to 1990, Colleges of Nursing and Midwifery (CNMs) usually trained as many students as they had capacity for, as this made an allowance for the 25% of students who went on to work outside Scotland (usually in England). However, since 1990 the number of student places has been determined by the predicted future needs of employers in Scotland rather than college capacity, or student demand for places (Nursing and Midwifery Education in Scotland: Options for the Future 1993).

A similar contracting system had existed between the health boards and CNMs since April 1993 (when the colleges became independently managed units). However, the document Review of Provision of Nursing and Midwifery Education in Scotland (1994) argues that health boards 'no longer have the need or skills to carry out workforce planning or educational contracting', and that they are not in a position to take a national view. Accordingly, the Review of Provision (1994) explains that educational contracting and assessment of employer’s workforce needs should be carried out centrally by the Scottish NHS Management Executive (Scottish Office 1995). Thus, currently the management executive asks trusts, health boards, and other health care employers to provide their existing and expected staffing levels (Scottish Office 1997). The data are then analysed to obtain a forecast on a 3-year rolling basis of the numbers of students required to begin studying nursing, and to determine levels of funding for such education.

Wales

Prior to 1990 student intake numbers to nurse education in Wales were agreed by the health authority and the school of nursing; the numbers were based on historical figures, and on pragmatic decisions (for instance, as funds allowed). However, since Towards 2000 (1993) student numbers have been calculated directly according to the number of nurses needed in the Welsh workforce. Therefore, training numbers were dramatically reduced. However, this reduction raised concerns from the Nursing Division at the Welsh Office and the members of the Education and Training Group (ETG), who recommended that the figures should be enhanced by 15% to allow for training wastage.

Nurse education commissioning is now administered centrally in Wales via the ETG, who recommend student nurse recruitment figures to the Executive Committee of the Welsh Office. The ETG is chaired by the Chief Executive of an NHS trust, and membership consists of health service professionals, and managers and officials from the Welsh Office. The ETG carries out workforce planning; in order to assess need, the ETG approaches health care employers, trusts, health authorities, GP fundholders, and employers in the private health care sector, to ask how many nurses they require for the next 3 years (Towards 2000 1993). The ETG then consider the analysis of these figures, and after taking advice from Welsh Office Professional Groups (such as nurse officers), adds
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figures accounting for wastage and other such factors to the original need figure. The group may also add a safety figure, if deemed necessary. Once the numbers have been agreed by the ETC and the executive committee, the Education Purchasing Unit (EPU) contracts with education providers for the numbers required. The EPU has executive function only.

Northern Ireland

Currently the DHSS (Health remains combined with Social Services in Northern Ireland) gives some purchasing funds directly to the Health and Social Service Area Boards, but gives the greatest portion of top-sliced money to the National Board for Northern Ireland (NBNI), who are still responsible for providing nurse education in Northern Ireland. The NBNI commissions education and training from the nurse training colleges, and thus distributes the bursaries, having been provided with funds and recruitment figures from the DHSS. However, in Northern Ireland nurse training is soon to be moved so that it is totally located in the higher education sector, and funded directly by the DHSS.

Therefore, the Department explains, the DHSS will have ‘the ultimate responsibility for identifying the level of demand which is to be met and collecting the information required’ (Working Paper 9 1990). The Department will ask all employers to provide information on existing staff numbers, projections of staff required to replace wastage over each of the next 5 years, and other aspects of the workforce. The manpower planning aim is self-sufficiency for Northern Ireland (although account must be taken of nurses leaving for other countries outside the province). The Department will consult employers and educators, with a Working Paper 9 Planning Group conducting the statistical projections in order to produce a final figure. The DHSS will determine the overall level of funding to be top-sliced.

Summary concerning the different systems

While theoretically there may be competition among higher education institutions for nurse education contracts in all four countries, it is only in England that purchasing power has been, to some extent, devolved to employers via the system of consortia. While there is little evidence that competition has occurred in England to an serious extent (consortia tend to commission provision from traditional providers), the possibility of competition exists. The recent withdrawal of contracts for nurse education with Portsmouth University provides an illustration of this (THES 1997). Yet in the other nations (Scotland and Wales currently, with Northern Ireland to follow shortly) purchasing has actually become more centralized, as it has been reclaimed from the National Boards and Health Authorities by the central government bodies in each count. This seems to contradict the rhetoric of the Conservative Government that instigated these new systems which tended to oppose central planning (Burke 1995). Possible explanations for this anomaly are considered next.

Is the system of consortia functioning efficiently in England?

Controversy rages in England over the issue of nurse shortages. On the one hand, the NHS Executive has argued any shortages are localize or limited to specialist areas (Nursing Standard 1997a), and on the other hand, the Royal College of Nurses (RCN) claims that the NHS is short of 8000 full-time nurses (Nursing Times 1998). Using quantitative workforce evidence to investigate shortages, Seccombe and Smith (1996) demonstrate that vacant and ‘permanently open’ posts have increased over the last few years, while numbers of frozen posts have fallen. They explain that combining these categories for matched samples reveals a 9% growth in total unfilled posts between March 1994 and 1995, and a shift away from frozen posts (indicating vacancies to are being filled as far as possible). This evidence seems hard to dispute, and indicates some shortages in nursing staff.

Any shortages in the current nurse workforce illustrate past planning errors concerning recruitment and retention. However, in order to fill any gaps, and to build up the workforce to meet future health care needs, these issues must be taken into account in current planning of nurse education recruitment figures. The NHS Executive acknowledges a need for more student nurse recruits due to demographic factors affecting health care. In 1996 they circulated the...
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Table 1 Number of pre-registration entries in England

<table>
<thead>
<tr>
<th>Year</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987/8</td>
<td>15,202</td>
</tr>
<tr>
<td>1988/9</td>
<td>15,905</td>
</tr>
<tr>
<td>1989/90</td>
<td>15,797</td>
</tr>
<tr>
<td>1990/1</td>
<td>15,452</td>
</tr>
<tr>
<td>1991/2</td>
<td>16,864</td>
</tr>
<tr>
<td>1992/3</td>
<td>15,921</td>
</tr>
<tr>
<td>1993/4</td>
<td>12,464</td>
</tr>
<tr>
<td>1994/5</td>
<td>10,844</td>
</tr>
<tr>
<td>1995/6</td>
<td>12,033</td>
</tr>
<tr>
<td>1996/7</td>
<td>13,924</td>
</tr>
</tbody>
</table>


calculation that there should be a 14% increase in nurse recruits, and recommended a 12.5% rise in student numbers for 2 years (EL(96)46). Figures from ENB Annual Reports show that, up to the college year 1996/7, the new recruitment demands have been met. Table 1 demonstrates that while pre-registration entries in England fell from 1991 to 1994, they rose during 1995-1997, from 10,844 in 1994/5 to 13,924 in 1996/7.

However, there is some evidence that in the year 1997/8, applications for nurse education were less than the places available (Nursing Standard 1997b). Moreover, some commentators suggest that the rises in student nurse recruitment (discussed above) does not go far enough (Naish 1995); indeed, the NHS Executive itself appears to acknowledge problems, as EL(96)46 (1996) argues that on top of their calculated 14% increase, 'A further substantial increase in training will be needed if future demand for qualified nurses grows'. The NHS Executive points out, however, that the extra 4000 training places needed to meet future demand will have to be phased in gradually (12.5% increases for the next 2 years) for practical reasons.

Thus, various evidence suggests that any current nurse shortage is set to become more severe due to a combination of demographic factors. This impending shortage in England has been recognized by the NHS Executive, which has taken pre-emptive steps to counter it. However, arguments persist over the size of the anticipated shortage, and whether or not the NHS Executive’s calculations concerning a 14% increase in nurse education recruits will be sufficient to neutralize this.

Such issues raise concern over the ability of consortia to identify such needs. Stock (1996) argues that planning 5 years ahead can be difficult, and raises concerns that few trusts have ‘reliable historic data upon which to base projections’, while many trusts lack expertise in workforce planning. The statistical analyses can be at fault for a variety of reasons and at a variety of levels (Stanwick 1994). Non-trust institutions (e.g. nursing homes, GPs, and the private sector) may not be fully represented in consortia, and, therefore, may not provide full figures, or model effectively. Moreover, it is possible that some trusts might submit inflated workforce plans thinking that they will win contracts because of this; Stock (1996) suggests that competing trusts may not want to divulge information concerning labour demand, as this may implicitly indicate service plans. Hence, consortia may sometimes lack the full workforce figures. Problems are compounded by the difficulty of integrating different planning cycles: consortia are supposed to model workforce need for 5 years ahead, whereas the Regional Office and NHS Executive are modelling shorter time-spans. It has been argued that some consortia are failing to conduct comprehensive workforce modelling far enough ahead (Stock 1996). This concern is reflected in EL(96)46 which ‘recognizes the need for better integration of medical and non-medical workforce planning’, and the planning of nurse recruit numbers.

These suggestions only represent one side of the story in a little-documented area. The Times Higher Educational Supplement (1997) observes a ‘lack of transparency’ in consortia decision-making; and the subsequent lack of documentation means that it is hard to know whether it is simply planning calculations, or other issues, that are impacting upon consortia workforce plans. For instance, anecdotal evidence suggests the possibility that messages about a need for greater recruitment, transmitted by workforce planners, are ignored due to attempts to meet the rigid cost reductions demanded by successive Conservative Government administrations.

The NHS Executive remains accountable to ministers, and has overall responsibility for nurse supply. As we have observed, they have their own systems for calculating demand for nurse education. Because of their overall accountability, it is in the interest of the NHS Executive to assist consortia in ‘getting it right’ by suggesting the increased figure produced by NHS Executive models (e.g. 12.5% over the next 2 years, in the case of EL(96)46). It would appear that
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Educational commissioning by consortia is not operating efficiently due to a lack of information, and, therefore, central guidance remains necessary. Obviously the consortia mechanism is a new one and it is hoped that, over the coming years, consortia will collate more information, and that the NHS Executive will be able to ‘let go of their hands’ and leave the market to operate on its own (Snell 1997).

EL(95)27 identifies a further function of consortia, in that in their role as educational commissioners they may be able to exercise influence over the qualitative aspect of education. In other words, they may influence the type of nurse education offered to students, and thus the abilities of the newly qualified nurses entering the workforce, making them more responsive to employer needs. Humphreys (1996) found little evidence of consortia exercising these powers, and this finding is supported by Oakley (1997, quoted in Snell), who maintains that currently consortia are focusing on ‘number-crunching’ at the expense of qualitative policy issues. However, consortia remain at an embryonic stage (Snell 1997), and further research would need to be conducted to ascertain whether consortia have become more involved in guiding the form of nurse education via their commissioning power.

Possible reasons for the non-acceptance of consortia in Scotland, Wales and Northern Ireland

There are three possible reasons why the consortia mechanism has not been adopted as a system for the commissioning of nurse education in the UK nations other than England. It could be argued that consortia will not be adopted in the other UK nations due to demographic factors: Scotland, Wales and Northern Ireland are far less populated than England, and Wales and Northern Ireland, particularly, would constitute the population of an English region. Hence, it might appear simpler to purchase nurse education centrally. Or possibly a consortia system will be developed in these countries at a later date, although there are no definite plans for this at present. The third possibility is that the consortia system is not perceived as functional by the central bodies in these nations. We have described how the central body (NHS Executive) in England is still involved in the purchasing of nurse education and plays a vital guiding role. And it is argued that in the other countries the central bodies have been dubious regarding the ability of health care employers to plan accurately their workforce needs.

In Scotland, the Scottish Office Review of Provision document (1994) argues that the management executive of the NHS in Scotland more equipped to carry out workforce planning than the health boards. In Working Paper 9 (1991) the Northern Irish DHSS explains how their assessment in nurse recruitment has become more rigorous due to awareness of the demographic trough. Thus they argue, ‘Both for this reason, because direct funding of certain training costs cannot be a blank cheque refunding employers whatever level of training they choose to provide or purchase, a (central) system for assessing manpower demand will continue to be necessary. Similar concerns about ‘getting the numbers right’ are used in Wales to justify central planning and purchasing. The document Towards 2000 (Welsh Office 1993) acknowledges that, ‘It is the Government’s policy that education/training should, wherever possible, be the responsibility of the direct employer at the operational level’ (p.1)

However, they go on to argue that various factors might lead to errors in employer manpower planning, and that central purchasing will provide a ‘level playing field’ when health care providers compete for contracts. Thus, it appears that in Scotland, Northern Ireland and Wales, centralized purchasing was preferred due to scepticism over the ability of employers to calculate efficiently their workforce requirements. The fact that in England the NHS Executive is still aiding consortia with workforce modelling seems to support such scepticism. While health care employers in Wales, Northern Ireland and Scotland are consulted concerning their workforce numbers (and subsequently, the extent of their demand for nurse education), the responsibility for modelling these figures, final calculation of demand, and the commissioning education, remains with the central bodies. Thus, while employer needs are considered, the act of commissioning process has actually become more centralized. However much the rhetoric of policy documents implementing changes in education commissioning supported devolution of control...
to employers, the outcome in the nations, other than England, has been very different.

Due to a lack of documentation regarding the level of shortages in different geographical areas, it is difficult to know whether the demand for education is being more adequately coordinated with the demand for new nurses in the labour market by the centralized models. Some urbanized areas face greater problems concerning shortages of nurses, but there are more of these areas in England than in the other UK nations. However, it can be maintained that if the consortia system is not demonstrably more effective than the centralized models, the latter may involve less paper-work and people-hours, and thus greater value for money.

Conclusions

It has been argued that despite Conservative Government rhetoric concerning employer control and the free market in nurse education (Burke 1995), the aspect of marketization of nurse education commissioning where responsibility is devolved to employers has only been attempted in England. In the other nations commissioning has, if anything, become more centralized. It is argued here that while practical issues may play a part in the non-adoption of the consortia commissioning system in these countries, the concerns over accurate coordination of demand for nurse students emanating from the respective government offices constitute a principal reason for their reversion to a centralized system. It was discussed how the NHS Executive in England is still taking responsibility for modelling workforce figures, and playing a guiding role in the commissioning process: this was argued to be necessary due to past planning errors and a lack of information at consortia level regarding the number of student nurse recruits necessary. The result, however, is that even in England, commissioning is not completely devolved. This conclusion raises a question-mark over the maintenance of the consortia system in England: if the NHS Executive is forced to continue in its involvement in the quantitative aspects of educational commissioning, and qualitative benefits fail to materialize, the argument that central planning is actually more efficient, and indeed cost-effective, may persist.

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This Network article offers a very insightful comparative account of nurse education commissioning policy in the UK. The article patiently builds the background and context of the whole area of commissioning in the UK. Within the background and context Francis and Humphreys argue that working paper 10 was, for England, one of the most influential policy papers. The other three UK countries (Wales, Scotland and Northern Ireland) all worked towards the ‘nurse education commissioning’ objective albeit using slightly different policies. Francis and Humphreys implicitly offer a very sound rationale for introducing the commissioning policy. The policy was intended to:

- Create a clearer distinction between the funding of education and service
- Ensure the involvement of the purchasers of nurse education in the thinking that informed curriculum or programmes of study
- Increase quality through healthy competition
- Involve higher education institutions in the provision of nurse education.

Within this broad rationale the exact mechanism by which each country operationalizes the commissioning policy appears to be the issue for critical discussion in this article. The article outlines the systems used in Wales, Scotland and Northern Ireland and then moves on to evaluate the use of consortia in England. Here the article becomes a little unclear. For instance, the role of the NHS executive and that of the trust consortia and their interaction needed spelling out more clearly for readers outside of the UK system. In addition to the ‘who is who’ issue there also needed to be an outline of the key issue of the intelligence that informs the decision making process of the NHS executive and the consortia. It, however, seems clear from the article that the consortia in England may be struggling with their manpower project on several counts. One of these counts cited in this article is the lack of representation across sectors. The other is the ‘ambitious optimism’ where inflated workforce plans may be perceived as potentially lucrative. A third count (seldom seen negative) is the contribution of those that are represented on the consortia. For example the advent of the Local Supervising Authority (LSA) has brought with it an LSA Officer who in some cases contributes directly to the consortia education planning (ENB 1998). The LSA officer role in midwifery includes meeting with supervisors of midwives within the consortia and improving communication. It could therefore be argued that the LSA Officer role now exists in midwifery as one way of improving representation of midwives on educational matters. The seeming irony of this role is that it too appears to be struggling to gain access to the contracting process and information needed to predict student numbers. This brief account supports Francis and Humphreys’ argument that the consortia approach as used in England is at the moment struggling to function efficiently. As the title of this article suggests there may still be the tension between devolution and centralization and until it is clearly one or the other nurse education commissioning remains a potent problem in England.

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Rationalisation and Professionalisation: a comparison of the transfer of registered nurse education to higher education in Australia and the UK

BECKY FRANCIS & JOHN HUMPHREYS

ABSTRACT During the latter part of the 1980s registered nurse education was transferred from hospital-based training to higher education in Australia and the UK. Examining this transfer process, analytical attention is focused on the contrast in subsequent funding arrangements for registered nurse education between the two nations. It is argued that the difference in funding arrangements can be explained by an analysis of two separate movements impacting on health care policy in both Australia and the UK: those of professionalisation in nursing and economic rationalisation. This paper discusses the implications of these movements and the subsequent differing educational funding arrangements in terms of the professionalisation of nursing in Australia and the UK.

Introduction

Over the last decade, policies of rationalisation (involving cut-backs and efficiency drives, see Halford et al. (1997)) and marketisation have been applied increasingly to state health care services in many First World countries (Gould, 1993; Mishra, 1993). In the majority of Organisation for Economic Cooperation and Development (OECD) countries, the demand for health care continues to grow as the population ages and increasingly articulate and informed patients demand more care. Governments have been searching for ways to lessen the financial burden which health services place upon the state, and many have experimented with the application of market approaches and incentives to state health care, as well as endorsing efficiency drives and ‘cut-backs’ in services supplied by the state.

Simultaneously, and partly because of the expansion and increased pressure on health care services, nurse training has been undergoing a transformation in these countries over the last decade, in terms of a move towards higher education. It has been possible to take degrees in nursing in the majority of these OECD countries for some time (indeed, in the USA the first pre-registration nursing degree programme was established in 1909. Although those holding baccalaureate degrees remain in the minority, they comprise around a third of the United States’ nursing workforce (see Commonwealth Department of Human Services and Health (1994)). Yet the vast majority of pre-registration nurses in these countries have traditionally been trained in hospital-based schools of nursing (gaining hospital-based diplo-
mas), rather than in higher education. The report *Nursing Education in Australian Universities* (Commonwealth Department of Human Services and Health, 1994) argues that in the last 20 years English-speaking nations have led the way in a developing trend to move registered nurse education from the hospitals’ control into the higher education sector: in New Zealand, Australia and the UK registered nurse training has been transformed from apprentice-style training in hospitals to higher education courses, and nursing courses in the USA and Canada are increasingly conducted at bachelor and post-graduate level.

The British scenario, however, is peculiar, in that funding for registered nurse education remains with the Department of Health. In other countries funding was gradually or immediately transferred from the government department for health to the higher education funding body when the higher education sector became the provider of registered nurse education. In the UK a decision was made to retain the funding with the Department of Health. This created a scenario where one government department (Health) effectively purchases the services delivered under the auspices of another (Education). At the time (the beginning of the 1990s) an ‘internal market’ was in place in the UK health care system, where Health Authorities purchased health care services from newly corporate National Health Service ‘trusts’ (hospitals, etc). The decision that the funds for nurse education should be retained by the Department of Health created a new ‘quasi-market’ in nurse education, separate from the internal market for health care (Humphreys, 1996; Francis & Humphreys, 1998). Indeed, while the internal market is currently being dismantled by the new Labour administration (Department of Health, 1997b; Dickson, 1997), the quasi-market in nurse education remains intact and is actually being strengthened—for example, the funds for nursing degree courses are to be transferred from the Higher Education Funding Council to the Department of Health (*Nursing Standard, 1997a; The Times Higher Educational Supplement, 1997*).

This paper reports part of an investigation into the reason for this funding anomaly in the UK (England, Scotland, Northern Ireland and Wales) system. In order to examine why the decision to retain nurse education funding with the Department of Health might have been made, we discuss the case of another country, in an attempt to shed light through comparison on the differences in policy between the different nations. Of the various OECD nations, Australia has been chosen as the focus of this comparison because of its parallels with the UK. Registered nurse education has followed a similar progression in the UK and Australia in recent years, in that it has converted from practice-based training located in hospitals to tertiary courses located in higher education institutions.

In Australia, the transfer of registered nurse education to the higher education sector was announced by Commonwealth ministers in 1984. Registered nurse training was to move into Colleges of Advanced Education (CAEs) and the move was to be completed by 1993 (see Crooks, 1997). The State Grant Act of 1985 announced that the qualification on completion of basic registered nurse courses would be an ‘undergraduate diploma’ (see Martins, 1990). In the UK the decision was made to transfer nurse education from hospital-based training to college-based education (mainly polytechnics), comprising ‘Project 2000’ [1] diploma courses, in 1989; the same year in Australia a ‘unified national system’ was introduced in higher education, ending the old binary system of universities and lower-status CAEs (see Gamage, 1993). And in the UK the polytechnics were awarded university status in 1992, after which the remaining colleges of nursing were quickly incorporated into the expanding universities. Hence, the path of registered nurse education has followed a very similar course in the UK and Australia over the last decade, and in both the UK and Australia the initial training of registered nurses is now located in universities.

However, regarding the funding of registered nurse education, the paths of the UK and
Australia were rather different. In the UK the money to provide nurse education was retained by the Department of Health, while in Australia the money followed registered nurse education into the higher education system, funding being transferred to the Department of Employment, Education, and Training. This paper examines the policy movements surrounding registered nurse education in the period leading up to and during the transfer, in an attempt to explain why this significant difference over funding for registered nurse education in the UK and Australia has arisen, when more generally the policies have been similar.

It is important to remember that while the UK is run by a central government, Australia is a federation of individual states. In Australia different policies on nurse education were adopted by different states at different times. For example, in New South Wales the state government awarded registered nurse education degree status before this had been approved as national policy by the federal government (see Martins, 1990). Moreover, besides policy variations within different states, there is a further important difference from the UK system, in that health care is the financial responsibility of the state governments, whereas higher education is the financial responsibility of the federal Commonwealth government. Therefore, the UK and Australia are not without significant differences. Notwithstanding this point, within the scope of this paper Australia provides a comparison of sufficient similarity to elucidate the peculiarities of the current UK dispensation.

Professional Pressure on Nurse Education Policy

It has long been argued that professions seek to increase their autonomy and status by self-regulation, and in particular, regulation of the professional entry-gate in order to maintain exclusivity (e.g. Johnson, 1972). The programme by which these factors are increased has been termed ‘professionalisation’ (Witz, 1992). The higher the entry-gate to a profession, the more exclusive the knowledge provided in training. By maintaining exclusivity, the profession ensures that its skills and knowledge are scarce, and, therefore, highly valued (see Ainley, 1994). But also, by controlling the type of education provided, the profession consolidates its hegemony over the type of knowledge which constitutes the professional. Therefore, it is no surprise that professions which have not achieved total autonomy and hegemony in the workplace, or which have room for improvement in these areas, engage in attempts at professionalisation. Nursing has traditionally been marginalised compared with other powerful health-care professions (particularly the medical profession). Consequently, it is an occupation which engages in professionalisation (see Moloney, 1992; Witz, 1992). Moloney (1992) argues that the standardisation of education with university preparation as a minimum requirement is one of the key dimensions of professionalisation. A move of nurse training to higher education achieves the aims of a higher, more exclusive entry-gate to the profession, and is thus appealing to the nursing profession. It also brings nurse education more into line with the training for comparable non-medical health professions (e.g. occupational therapy, physiotherapy, etc) and, hence, has improved the status of nursing as a career. Moreover, by moving nurse education away from hospitals (and the control of health care employers) and into the higher education sector, the nursing profession can arguably gain a greater level of control over the constitution of nursing (Humphreys, 1997).

It is argued here that the nursing profession, with its desire for the professionalisation of nursing, dominated policy development and decisions concerning registered nurse education in the UK and Australia throughout the 1980s.

In the early 1980s, there was concern for the future of nurse education in both the UK
and Australia. The nursing profession voiced anxiety regarding the status and effectiveness of apprenticeship-style nurse training (where nurses were trained 'on the job' in hospitals), and its impact on the status of the profession, the morale of nurse students, and the numbers of students not completing courses (see United Kingdom Central Council for Nurses, Midwives and Health Visitors (1986) and Royal College of Nursing (1985) in the UK; and Parkes (1986) and Royal Australian Nursing Federation et al. (1975) in Australia). The solution was seen by the professional bodies as the termination of hospital-based training and the transfer of registered nurse education into higher education.

In Australia, as in Great Britain, concerns had been raised regarding the status of nursing and its appeal as a professional career. Parkes (1986) explains how many nursing organisations had been pressing for the move of registered nurse training to higher education for nearly two decades. In 1976, Goals in Nursing Education was produced as a collective policy statement by various professional nursing bodies of Australia, arguing that hospital-based training was inflexible and 'totally inappropriate' in contemporary society (Royal Australian Nursing Federation et al., 1976, p. 10), and unable to meet the nursing needs of the changing Australian community. The statement argued for basic nurse education courses to be transferred to CAEs. Although there was some initial resistance to the idea of a transfer from government bodies (see below), the reports of the government-appointed commission on nurse education became gradually supportive of the idea. In the Advanced Education Council of the Commonwealth Tertiary Education Commission's Report for the 1985-87 Triennium (1984), it was argued that the transfer of basic nurse education to CAEs was justified due to the changing health care environment. The report pointed out that in apprentice-style training service needs overshadow those of education, meaning that theory is neglected. It was argued that contemporary registered nurse education should prepare nurse students to meet the 'total health care needs' of the future; and multi-disciplinary, tertiary settings would be more conducive to such education. It also observed the concerns of nursing bodies that registered nurses require college-based training to secure equal professional status with other non-medical professions.

In the UK the Royal College of Nursing produced The Judge Report in 1985, which investigated then hospital-based nurse education, identifying high wastage levels amongst student nurses during training. The report linked wastage to the exploitation of student nurses as a vital component of the nursing workforce, and argued that student nurses should be freed from the obligations of work in order to concentrate on learning (Royal College of Nursing, 1985).

These recommendations were symptomatic of a growing concern about the ability of nurse education to produce a numerically sufficient supply of qualified nurses, and nurses with the increasingly sophisticated skills necessary to operate in acute and community-based nursing environments. Certainly there was concern regarding the future path for registered nurse education in the light of a changing nursing environment throughout the British nursing profession: in May 1985 the English National Board also published a document on the future of nurse education (English National Board, 1985), with broadly similar conclusions to those of the Royal College of Nursing. In 1986 the United Kingdom Central Council for Nurses, Midwives and Health Visitors published the results of its own inquiry into nurse education; 'Project 2000'. This investigation had considered the future of nurse education in the light of various demographic trends and the health care needs predicted as a consequence of these. There was consensus in all three reports that educational standards could best be enhanced by breaking the traditional apprenticeship model (where the student nurse was relied upon as an 'extra pair of hands' in the workplace, see United Kingdom Central Council for Nurses, Midwives and Health Visitors (1986)) and placing nurse education under the
control of educationalists in a supernumerary model. Although practical experience would remain an important feature in any new type of training, this would be unpaid—student nurses would instead be bursaried—and the student would no longer be part of the rostered workforce until much later in their training. Therefore, the relationship between the student and the workplace would be greatly altered, with the onus on learning rather than meeting service needs. The reports agreed further that the registered nurse education award should take the form of a higher education diploma. Thus, the changing and challenging demands of the future National Health Service would be met by a highly qualified and more flexible nurse; her/his role extending beyond traditional areas to cover health education, sophisticated clinical practice, and community care.

So the arguments for the transfer of registered nurse training were similar in the UK and Australia, and in both countries the proposals for change were steered by the nursing profession. These proposed changes obviously stood to benefit the nursing profession as a whole, as well as arguably creating a more effective system of nurse training. The move of registered nurse training into higher education would bring it more into line with the training for comparable professions and, hence, would improve the status of nursing as a career (see Commonwealth Department of Human Services and Health (1994)).

**Government Resistance**

However, the original proposals were not accepted by the various governments without mitigation. Particularly in Australia, where the proposals to transfer registered nurse education had been formulated earlier than in the UK, there was some initial resistance from the then Liberal-National Party Government (Parkes, 1986). The Sax Report (Sax *et al.*, 1978) responded to the nursing bodies' *Goals in Nurse Education* (Royal Australian Nursing Federation *et al.*, 1976), allowing that more diversity was required in nurse education. However, the subsequent Commonwealth Tertiary Education Commission's Triennial Report (1978) rejected the idea of an outright transfer to higher education for the time being. The commission proposed that the majority of registered nursing courses should be retained in hospitals, but that these courses would be improved through an affiliation with higher education institutions. This response angered nursing bodies, and the following Labor government came under strong pressure from the Australian Nursing Federation to review that conclusion in the early 1980s. At its sixth national conference held in Adelaide in May 1984, the College of Nursing also rejected the commission's recommendations, and called on the federal government to make a commitment to transferring nurse education to CAEs by 1990. The federal (Labor) and state governments subsequently faced increasing pressure from nurses and their unions, including the threat of strikes (Parkes, 1986); and Martins (1990) describes how finally Prime Minister Hawke himself personally intervened to assure nurses that registered nurse education would be transferred into CAEs. The Commonwealth government responded by introducing six pilot courses in higher education institutions leading to diploma qualifications in nursing. However, they refused to increase the numbers of such courses for the time being.

One of the main disadvantages government bodies saw to the proposals for transferring registered nurse training to the higher education sector was the cost of implementation. In Australia, the *Report for the 1985–87 Triennium* (Advanced Education Council of the Commonwealth Tertiary Education Commission, 1984) identified this as a major draw-back. In the UK, tuition costs in higher education institutions approached four times that in schools of nursing (see Humphreys, 1996). Moreover, assuming a 60–65% reduction in student contributions in the UK National Health Service workplace, it was estimated that the National Health Service would need to recruit 21,000 extra ward staff, at a replacement
cost of £110 million a year (at 1982/1983 prices; Goodwin & Bosanquet, 1986). While these replacement costs would be offset by the reduction in payments to students as their status changed from paid employees to bursaried students, it was nevertheless estimated that in the UK the overall cost of nurse training would rise by around £32 million (Goodwin & Bosanquet, 1986), again, at 1982/1983 prices. Then there was the issue of the probable higher cost of employment of nurses, following the professionalisation of nursing as a result of Project 2000 (see Ranade, 1994). So at a time when governments were attempting to reduce spending in the areas of health and education, the transfer of registered nurse training appeared set to increase cost in these departments.

The Supply of Nurses

However, the nursing profession used the issue of supply of nurses to counter the apparent disadvantages of Project 2000 in terms of cost. The United Kingdom Central Council for Nurses, Midwives and Health Visitors (1986) argued that Project 2000 diploma courses would reduce training wastage and make nurse education more appealing to potential students.

The question of nurse supply is a politically contentious one, as a shortage of nurses can suggest neglect or deterioration of the health services to the public at large (see Francis & Humphreys, 1998). Thus, it is in the interest of governments to ensure an adequate supply of nurses to the health care workforce. The majority of new nurses to the health care labour market are drawn from a pool of newly qualified nurses, trained on nurse education courses. Therefore, the continuing recruitment of sufficient numbers of nurse students is vital to avoid shortages in the labour market. In the 1980s concern had been raised that demographic factors leading to a growing demand for health care and a decrease in new recruits into nurse training would mean that contemporary shortages in the nursing workforce were set to increase (Conroy & Stidson, 1988). The ageing population in the UK and Australia meant that the nations' health care needs would continue to escalate rapidly (Australian Institute of Health and Welfare, 1995; Seccombe & Smith, 1996). However, many studies published in the mid-1980s suggested that the nursing workforce was not growing at an adequate rate in order to cope with this rising demand (see, for instance, Conroy & Stidson, 1988). Seccombe & Smith (1996) argue that the nursing workforce is itself ageing, due to a lesser proportion of new recruits: obviously once the older nurses reach retirement age, shortages may increase. The two main solutions to this potential crisis were seen as a reduction in nurse and student nurse wastage, and increases in student nurse recruitment (see also Commonwealth Department of Human Services and Health, 1994). As the UK Royal College of Nursing (1985) had observed, there was an acute problem of student wastage on nursing courses (wastage was standing at 20%). The proposals for the transfer of registered nurse education appeared able to remedy both these aspects. 'Project 2000' courses, and indeed the higher education diploma courses in Australia, were seen as being more thoroughly geared towards the learning needs of the students than the previous apprentice-style courses, with the pressures and contradictions of work in the hospital ward alleviated. Thus, it was expected that with the introduction of the new diploma courses, wastage could be halved (United Kingdom Central Council for Nurses, Midwives and Health Visitors, 1986). Moreover, a higher education diploma course might be more attractive to potential nurse recruits, as such a course would make nursing more comparable with other professions allied to medicine and, hence, keep careers in nursing competitive (this argument is now being used in the UK by the Royal College of Nursing to support the elevation of pre-registration training to degree level: Nursing Standard, 1997b).
Alternatively, another method of recruiting a greater number of students to nursing courses not supported by the professional bodies would have been to lower the entry requirements for nurse education. That this option was not seriously considered illustrates the success of the nursing profession in leading and driving the debate at the time.

Salvage (1988) has argued that Project 2000 was a strategy by the nursing profession to pre-empt any government inclination to increase the numbers of student nurses by lowering the entry-gate. But the professional strategy appeared successful. It is suggested here that one of the main reasons that the high cost of transfer was accepted by the governments in Australia and the UK was the potential of the new nursing diploma courses to attract and retain greater numbers of students. The evidence for lower wastage rates as a consequence of the higher education courses is actually debatable: certainly in Western Australia, student wastage has been more than halved on nursing courses since the move into higher education (see Department of Health for Western Australia, 1995), yet there is less conclusive evidence in other Australian states. Wastage rates have fluctuated since the introduction of Project 2000 in the UK (and indeed they temporarily increased in some areas of nurse education in the years following its introduction), but they have decreased in England in the years 1993–1996; English National Board Annual Report (1993–1997) figures show that in general nursing education wastage rates fell from 14% of yearly entrants to 6%.

The Transfer to Higher Education, and Subsequent Funding Arrangements

On 24 August 1984 the Australian Education, Employment and Health Ministers issued a joint statement, that subject to a cost-sharing agreement with state governments, there would be a complete transfer of hospital-based nurse training to higher education institutions, beginning the following year and to be completed by 1993. The following State Grant Act (1985) stated that basic nurse undergraduate courses would comprise a diploma. While many nurses favoured a degree course (see Parkes (1986) and Royal Australian Nursing Federation, 1976), the transfer to higher education was their main priority at this time (Martins, 1990). Hospital courses were to be phased out gradually by 1993, with the final intakes in 1990. Nurse training in Australia had previously been state funded from the health budget, whereas Australian higher education had mainly been funded by the Commonwealth since 1974. Therefore, during the interim transfer period there was cost-sharing between the Commonwealth and state levels of government. The Department of Community Services and Health's Progress Report to Parliament (1990) explains how the Commonwealth paid $1500 per student each year until 1993, when the Commonwealth was due to take over total financial responsibility for registered nurse education as with all other higher education courses.

In the UK the Department of Health was signalling a favourable response to the Project 2000 proposals by 1988, and Project 2000 was officially endorsed by the government in 1989. By April 1996 all the hospital-based schools of nursing had been integrated into higher education, and nurse training courses comprised Project 2000 diplomas. The adoption of Project 2000 as national policy constituted a victory for the nursing profession, as it greatly strengthened the influence of professional nurses on the shape of nurse education. Previously nurse education had been run and funded by District Health Authorities; but as it moved into higher education the influence of District Health Authorities over nurse education was eroded. Changes such as these enhanced the autonomy of the nursing profession by decreasing non-professional influence over nurse training, an effect which implicitly strengthened the ability of the profession to define its practice with reduced consideration of the priorities of the employer (Humphreys, 1996). UK professional nursing bodies were
strengthening their control over the definition of nursing: they were successfully defining the type of training required to produce a particular type of nurse. In this professional progression, the situations in Australia and the UK were similar. However, unlike Australia, in the UK the funds for nurse education did not transfer to the higher education funding bodies at the time of transfer. We now discuss why this might have been.

Rationalisation and Marketisation of the National Health Service in the UK

A brief explanatory note should be made here concerning 'Thatcherism', the political approach taken by the Conservative Prime Minister Margaret Thatcher during her governance in the 1980s, and which was reflected in the policies of the subsequent Major government of the early 1990s. This approach drove government policy during the period of the changes to nurse education. Letwin (1992) reports that many consider Thatcherism synonymous with 'market liberalism', the central principle of which is that economic efficiency will be increased by a lack of state interference (see Kavanagh, 1990), allowing the free market to develop on its own. Thatcherism drew on monetarist principles, placing faith in the control of money supply in order to control inflation (Smith, 1987; Letwin, 1992). The power of unions and professions also had to be controlled, because union power could lead to creeping inflation (Smith, 1987). Faith in the free market and suspicion of workers groups are two factors which explain the Thatcherite concern to empower employers: the issue of employer power is revisited later in this paper. These inclinations were strongly apparent in relation to public and social policy.

In 1989, the White Paper Working for Patients was published (Department of Health, 1989a), with massive implications for the future of the UK National Health Service. The Thatcher-led Conservative government had been facing heavy criticism for its management of the National Health Service from the opposition, and from the medical profession. The National Health Service was already facing a dramatic funding shortage: as Holiday (1995) observes, while spending on health increased under the Conservative government year on year, the growth in demand for National Health Service services far out-stripped this spending, leaving the National Health Service in crisis. Forced to take the initiative, and ideologically opposed to increases in public spending, the government began to examine ideas for a radical over-haul of the National Health Service, with rationalisation and efficiency as fundamental priorities. Marketisation (recommended by right wing think tanks such as the Centre for Policy Studies, and the Adam Smith Institute) became the favoured option (Holiday, 1995). Working for Patients (Department of Health, 1989a) was implemented through the National Health Service and Community Care Act (1990). This introduced the concept of an 'internal market', imposing a 'purchaser/provider split' in the National Health Service (see Klein, 1995; and Holiday, 1995). District Health Authorities were divided into separate purchaser and provider organisations (new 'Health Authorities' and 'National Health Service Trusts', respectively). It was expected that the introduction of competition to the National Health Service, via the creation of the internal market, would increase efficiency and 'value for money'.

The Impact of Marketisation on UK Government Policy Concerning the Funding of Nurse Education

The creation of an internal market in health care raised important issues concerning the funding of nurse education. Previously the funds for nurse education had been largely conflated with the funds for health care delivery, all within the District Health Authority.
However, if this arrangement was retained in the internal market, the new National Health Service trusts might seek to cut the costs and level of education, in order to achieve reduced health care prices in the short term (see Humphreys (1996) and Stanwick (1994)). Thus, it was agreed in *Working for Patients* (Department of Health, 1989a) that to avoid training being cut back a new arrangement should be sought for educational funding, whereby these funds would be separated out from health service monies. An investigation of the issue was commissioned, the recommendations of which were published in another consultation paper: *Working Paper 10: Education and Training* (Department of Health, 1989b).

Meanwhile, following the acceptance of the Project 2000 development in 1988, the government had commissioned management consultants Peat Marwick McLintock to examine the roles of the UK Central Council for Nurses, Midwives and Health Visitors, and the four UK National Boards for nursing. The resulting report was critical of the then funding arrangements for nurse education, whereby nurse educators were funded through the statutory nursing bodies, while post-registration training, buildings cost, etc., were paid for through the District Health Authorities. They identified two possible ways to improve the situation; the first option being the transfer of education funding to the District Health Authorities; the second transferring funding to the National Boards of Nursing, allowing them to take over the control of nurse education institutions. Questioning the District Health Authorities' commitment to education, the final report recommended the latter option (Peat Marwick McLintock, 1989). Had these recommendations been adopted, the statutory (professionally dominated) nursing bodies would have directly controlled funding, management, regulation, and provision of nurse education. Humphreys (1996, 1997) argues that this would have consolidated professional control of nursing in the UK to an exceptionally high degree.

However, the publication of the Peat Marwick McLintock (1989) report and *Working Paper 10* (Department of Health, 1989b) virtually coincided. The latter was published only 2 months after the Peat Marwick McLintock report, yet the recommendations of the two were fundamentally different. While the Peat Marwick McLintock report recommended centralised control of funding, autonomous nurse education independent of the health service, and emphasised professional involvement, *Working Paper 10* suggested a devolved approach in which Regional Health Authorities would be largely responsible for the allocation of funds to nurse education in close consultation with National Health Service Trusts. Hence, the funds would be provided by the Department of Health. (The paper also encouraged the formation of 'consortia' representing the various National Health Service and private sector employers, as future commissioners of nurse education.) We can see that the Peat Marwick McLintock report, commissioned in response to policy influenced by the nursing professions, recommended a method of funding nurse training which further empowered the nursing professions. *Working Paper 10*, on the other hand, commissioned in response to requirements for marketisation of the National Health Service, recommended a system where health care employers would retain a controlling influence (through funding) over nurse training.

However, the professional response to *Working Paper 10* was not positive, while the Peat Marwick McLintock recommendations were embraced by the nursing profession (see United Kingdom Central Council for Nurses, Midwives and Health Visitors, 1990). However, it was the former report which was adopted as policy by the Conservative government. This decision was crucial in marking a turning of the tide in nurse education. *Working Paper 10* shifted the balance of control over nurse education away from the nursing profession, and back towards employers (Humphreys, 1996). When announcing the Conservative rejection of the Peat Marwick McLintock recommendations in favour of *Working Paper 10* in 1991, William Waldegrave (then Secretary of State for Health) explicitly stated
that decisions about the supply of nurses should be governed by service employers in order to ensure responsiveness to workforce requirements (Department of Health, 1991). By 1992 the elements for a quasi-market in nurse education were in place: on the demand side the Department of Health provided funds for nurse training. Regional Health Authorities advised by National Health Service Trusts would purchase nurse education from a supply side of higher education institutions.

The creation of a quasi-market in nurse education via Working Paper 10 (Department of Health, 1989b) should not be interpreted as deliberate, holistically planned policy development on a par with the creation of the internal market. Humphreys (1996) maintains that from 1989 the market actually emerged incrementally as the result of policy fall-out from the creation of the internal market for health care, and that while Working Paper 10 was laced with liberal free market ideology it was actually primarily a pragmatic response to ensure that the price mechanism in the internal market would not be corrupted by the funds for nurse education. However, we argue that the particular decision to maintain the funding for nurse education within the Department of Health was a deliberate and considered one. Transferring the funds for nurse education to the education department (as the Peat Marwick McLintock report suggested) would have involved handing control of nurse training to educationalists. By keeping the funding with the Department of Health and subsequently locating the education purchasing function with consortia of National Health Service Trusts, the government ensured that nurse education courses would primarily reflect service needs (articulated by health care employers). In this way the policy was in keeping with the Conservative government’s drive to stem the power of the professions (see Harrison & Pollit, 1994), and to empower employers.

Hence, this market-driven reform impacted upon nurse education at a crucial moment, blocking the finalisation of professional control of nurse education by withdrawing the proposed control of funds by professionally dominated statutory bodies, and instead handing this control to the new National Health Service employers. Thus, it is argued that the Peat Marwick McLintock proposals were about to seal professional control of nurse training in the UK, placing funds for nurse training in the hands of educationalists, as occurred in Australia. But monetarist concerns to empower employers and reduce the power of the professions led the Conservative government to reject that conclusion, and instead to retain the monies for nurse education in the Department of Health. The resulting market configuration can be seen as determined by the intersection of two different policy processes: on the supply side nurse education now comprised professionally dominated Project 2000 courses, located in higher education, while on the demand side there was reduction in the influence of professionally dominated statutory bodies in favour of employer control.

**Rationalisation in Australia**

As has been explained, Australia faced similar problems over the burgeoning cost of health care in the 1980s. Throughout the Hawke and Keating Labor administrations, economic rationalisation was implemented in the form of spending cuts and a drive for greater efficiency (Commonwealth Department of Human Services and Health, 1994). Policies of marketisation and competition have been influential in shaping development in education during this period (see, for instance, Margison, (1993); Australian Department of Health (1994), Hager, (1994)). Vidovich & Porter (1997) argue that the creation of the Department of Employment, Education and Training was, ‘a clear signal that economic matters would “drive” education’ (p. 236). In health care too, many state governments initiated managerial and market-driven changes (Commonwealth Department of Human Services and Health,
However, in both education and health, this rationalisation was implemented later than it had been in the UK [2]. Monetarist policies in health care have been in greater evidence since the election of the Liberal–Nationalist government under Howard in 1996 than during the previous Labor administrations.

Because health care is a state responsibility in Australia, the federal government had little formal control over health care policy: any new policy directions including reorganisation or rationalisation of services were implemented at the discretion of state, rather than Commonwealth, government. This suggests an important difference between the Australian Commonwealth and British governments in their approach to the transfer of registered nurse education from hospitals to the higher education sector. The risks posed by the transfer included the possibility that the cost of nurses in the workforce would increase as a result of their higher education training (Ranade, 1994); and a possible loss of control on the part of health care providers over the direction and content of nurse training and (consequently) the nursing profession. In the UK these risks constituted a problem for the central government, who was both responsible for health services and paid for them. However, because the Australian Commonwealth government neither funds nor has responsibility for health care, it would have been less concerned about this.

Yet the Commonwealth government was undertaking to fund registered nurse education from 1993, when all pre-registration training would be conducted in the higher education sector. This in itself constituted a new area of responsibility and expenditure to the Commonwealth government. The federal government’s commitment to improving opportunities and working conditions for women provides an explanation for this readiness to take on such extra responsibility. Martins (1990) explains how Dr Blewett, then Commonwealth Minister for Health, believed that the transfer would increase educational and employment opportunities for women. As in the UK, women comprise over 90% of the nursing workforce in Australia. By transferring registered nurse education to the higher education sector, access to higher education was provided to nursing students, of whom the vast majority were women (Commonwealth Tertiary Education Commission, 1987).

To recap, we argue that a combination of two factors explains why funding for registered nurse education was transferred to higher education in Australia but not in the UK.

Firstly, the possible financial costs in wages as a result of the higher status pre-registration training, and loss of control over the nature of education provided during this training, prompted less immediate concern in the Australian Commonwealth government, as they do not fund the health care sector. Secondly, the difference in attitudes to the health service between Prime Minister Hawke and his Labour government, and that of the UK Conservative government. The Australian Labour government was committed to improving opportunities for women, and had consequently resolved to upgrade nurse education (see White (1996) and Martins (1990). Moreover, while embracing some economic rationalist policies, the Hawke administration was less hostile to public services and to the professions than was the UK Conservative government. In other words, in Australia, the professional agenda of nursing was not intersected by Thatcherite policies, as was the case in the UK. More thorough monetarist policies are currently being implemented in Australia by the Howard administration; but nursing is already firmly ensconced in higher education funding.

Outcomes in the UK and Australia

In Australia, the transfer of funds to the Department of Employment, Education, Training and Youth Affairs means that nursing courses are funded like any other university course. This does mean that some discretion can be exercised by the university institutions in the
level of provision of funds for nurse education courses, which may not always favour nursing courses (for instance, other departments might be prioritised at the expense of nursing). However, in terms of professionalisation of nursing, the transfer of funds has been beneficial. It means that registered nurse education is dealt with in the same way as other non-medical health professions, increasing the comparative status of nursing—often viewed as a ‘semi-profession’ (Etzioni, 1969; Moloney, 1992)—as a consequence (Commonwealth Department of Human Services and Health, 1994). Moreover, it puts qualitative control of nursing in the hands of educationalists, rather than health care employers: health care employers cannot use funding to influence the type of education provided. Hence, the decisions over the type of training provided to a student nurse, and, thus, the type of nurse produced, are controlled by nursing academics and professionally dominated statutory bodies. The numbers of nurse students, and the issue of nurse shortages, remain a concern in Australia (Commonwealth Department of Human Services and Health, 1994; Department of Health for Western Australia, 1995), particularly as health departments no longer retain a formal influence. Close working groups and committees have been put in place to ensure co-operation between the health and education departments, with penalties if the committees’ requirements are not met by higher education institutions. Yet employers retain no formal control over the length of the course or the course content. Without a market mechanism employers lack the influence which educational purchasing provides to UK health care employers.

Once the transfer of funds had been made in Australia it was relatively straightforward to move the pre-registration qualification from diploma to degree level. While the transfer of nursing to tertiary courses located in higher education institutions had always been the priority for the Australian nursing profession, many had also campaigned for registered nursing to be a degree level qualification, Royal Australian Nursing Federation (1976) explicitly encouraged the growth and support of degree courses in nursing. In 1990 the years of campaigning bore fruit when the Australian Education Council accepted the recommendation of the final Working Party on Nurse Education report that the nursing award be changed from diploma to degree status, to commence from 1992. As promised, in 1992 registered nurse education became a degree course: professionalisation in Australian nursing was complete, with nurses enjoying the same educational status as the other non-medical health professions.

In the UK, however, because employers retain an influence in the contracting of nurse education, their needs can be reflected in both the numbers of students entering nurse training, and the focus of nurse training provided (and consequently, the type of nurse produced; see Francis & Humphreys, 1998). In England consortia of health care employers calculate the numbers of new nurse students required based on their estimates of future workforce needs. They then commission nurse education from higher education providers: by controlling commissioning they also have the mechanism to influence the type of education given to new students. (In the other UK countries the health departments of the various government offices approach Health Authorities and National Health Service Trusts concerning their workforce requirements, and commission nurse education based on their subsequent calculations.) Since April 1998 funds have been devolved from the Department of Health to successful consortia in England, who have taken full responsibility for purchasing nurse education direct from higher education institutions (see Department of Health, 1997a). The funds for nursing degrees, currently handled by the Higher Education Funding Council, are also to be diverted to health care consortia (The Times Higher Educational Supplement, 1997). Therefore, the retention of funds for nurse education with the Department of Health has ensured that employers can retain a considerable influence over the constitution of nursing courses, and over the direction of the profession as a consequence.
Arguably professionalisation of nursing has been impeded by this influence of employers over the direction of nursing. In comparison with Australia, professionalisation of UK nursing has not achieved complete hegemony over the constitution of nursing courses (and subsequently, the type of nurse produced), and did not achieve the elevation of the status of nurse education to a level comparable with other professions allied to medicine (which usually train at degree level). Both these failures of the professional project can be attributed to the retention of funding with the Department of Health, rather than being transferred to the higher education sector. Our analysis suggests that, had the Thatcherite agenda not impacted upon the progression of the transfer of nurse education in 1989 (via Working Paper 10), the funding for nurse education would have transferred to the Higher Education Funding Council, and the subsequent status of nurse education might now be similar to that in Australia. The professional and trade union group, the Royal College of Nursing, and other professionals are currently campaigning for all pre-registration nursing courses to lead to university degrees (see Langstaff (1997) and Birchenall (1997)), and it will be interesting to see whether health care employers will use their purchasing power to resist the nursing professionals and delay the move. Recruitment to nurse education remains a concern in the UK (Nursing Times, 1998), and the Royal College of Nursing argues that pre-registration degree courses would be more attractive to potential students than a diploma course. However, such a move would also bar potential students without the necessary qualifications from enrolment on a degree course. Therefore, employers might resist the elevation of pre-registration nurse education to degree level. Because employers control the commissioning of nurse education courses in the UK, it remains possible for them to do this.

Conclusion
We have argued that the difference in the funding arrangements for higher education-based registered nurse training courses had impacted significantly on the level of professionalisation of nursing in the UK and Australia.

In Australia the phase of nurse professionalisation in which registered nursing courses become conducted in the higher education sector at degree level was completed due to a combination of two factors. Firstly, the particular funding arrangements for health and higher education in Australia: because the federal government was not responsible for the cost of health care provision, other policy concerns (i.e. improving opportunities for women) outweighed concerns regarding potentially increasing costs implied by professional control of nursing; and secondly, the early start of the professional campaign, which became accepted before radical monetarist policies had been fully developed, especially with reference to health care. A lesser degree of enthusiasm for monetarist policies existed in the Hawke Labor administration, in comparison with the Thatcher Conservative government presiding in the UK at the time of the decision to transfer registered nurse training into the higher education sector. Because the nursing profession began campaigning for a transfer of nurse training into higher education institutions in the 1970s, by the early 1980s this campaign had gained credence in the eyes of Australian Labor politicians, and had been given recognition and support as part of their policy to improve opportunities for women. The transfer to higher education was thus implemented by a Labor government, before monetarist discourses and policies had gained momentum. Moreover, the state Departments of Health and Family Services were ready to allow the responsibility for funding registered nurse education to transfer from themselves to the federal government. Whereas in the UK, while nurse education was successfully moved into the higher education sector, the monetarist and anti-professional concerns of the government of the day led to a decision being made where
the Department of Health retained the funds for nurse education. The subsequent arrangements for commissioning nurse education have ensured that employers have a direct influence (via consortia) over the amount and type of nurse education contracted. This illustrates how apparently similar governmental approaches to public sector institutions can have significantly different results depending on the precise shape of the policies concerned.

We argue that as a consequence of the different funding arrangements, the rate of success of the Australian and UK professional projects in nursing has diverged. The Australian higher education project was completed, with nurse educationalists and statutory bodies controlling the constitution of registered nurse training courses, and pre-registration courses leading to degrees. In Australia, nursing now shares a comparable educational path and status with other professions allied to medicine. Thus, registered nursing has dramatically increased in status, and nurse educators and statutory bodies control the entry level and type of education provided—and consequently the type of nurse produced.

Conversely in the UK the professional project of nursing has been moderated by employer power and the type of nurse produced can be influenced by the needs of employers. While the higher education diploma in registered nursing has increased the prestige of nurse education (and consequently the status of nursing), the professionalisation project has by no means been completed. Because of the quasi-market arrangement where the Department of Health retains the funds for education, and consortia of health care employers increasingly purchase nurse education directly from education providers, employers are well positioned to hinder or restrain the professionalisation project, and we argue that this has happened. We have shown it to be the case that UK employer control over the nursing profession has been tightened, whereas in Australia the profession has more autonomy, and less fettered control of nursing. It remains to be seen whether or not employers begin to use their still new contracting power to manipulate further UK nurse education.

NOTES

[1] 'Project 2000' is the name of the higher education diploma courses in nursing, introduced in 1989 to provide the registered nursing qualification.

[2] Vidovich & Porter (1997) quote a university administrator who argues educationalists in Australia were watching the progress of the rationalisation programme in the UK closely, and learning from their mistakes.

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Enrolled nurses and the professionalisation of nursing: a comparison of nurse education and skill-mix in Australia and the UK

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Abstract

In the UK prior to 1989 two levels of nurse were trained: first level, or 'Registered Nurses' (RNs), and second Level, or 'Enrolled Nurses' (ENs). In 1989 changes to nurse education driven by 'Project 2000' marked the end of EN training: nurse education moved into the higher education sector and a single type of RN education replaced the original split-level training. Yet in Australia, where RN training has followed a similar path into higher education, the split level training of ENs and RNs has been maintained. The reasons for this difference in approach to ENs are investigated and discussed. The paper goes on to explore the implications and possible outcomes of the two different approaches in terms of the professionalisation of nursing and skill-mix in the health care workforce. Now that some UK nursing bodies are pressing for a degree-led profession, it is suggested that the Australian model may have an advantage, as concerns are being raised that English nurses may 'price themselves out of the market', with the nursing role being encroached upon by non-nurse Health Care Assistants. © 1999 Elsevier Science Ltd.

1. Introduction

Over the last decade, nursing has been under-going a process of professionalisation in many Western countries (Parkes, 1992; Humphreys, 1996). The report Nursing Education in Australian Universities (National Review of Nurse Education in the Higher Education Sector, 1994) explained how Registered Nursing has progressed from hospital-based training to more prestigious provision in higher education institutions in the majority of English-speaking countries and that the profession has gained status because of this.

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Simultaneously, healthcare and other public services have been increasingly rationalised or marketised (Gould, 1993; Mishra, 1993). In the majority of OECD countries, the demand for healthcare continues to grow as the population ages and increasingly articulate and informed patients demand more care. Governments have been searching for ways to reduce the financial burden which health services place upon the state. Of these various OECD nations, Australia was chosen as the focus of our comparison with the UK on policy developments in nurse education, due to some parallels between the two. For example, like the UK nursing register, the Australian nurse register is split between first and second-level nursing. Moreover, nurse education in these countries has followed a similar path from hospital-based education to higher education during the last decade, as we explain below.

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There are, however, some important differences in government structure between the UK and Australia. Australia is a federation, with the Commonwealth (federal) Government providing the funds for higher education, while funding for health care is the responsibility of the different State Governments. The UK incorporates four different nations but is governed by (and health care and higher education are funded by) a central government in London. However, the political climates in Australia and the UK at the time that the changes in nurse education under consideration shared some similarities. While a Conservative government led by Margaret Thatcher held power in the UK (from 1979), and a Labor government headed by Bob Hawke presided in Australia (from 1983), both these governments shared a Liberal enthusiasm for the economics of the market. Both governments were attempting to cut down on public spending by rationalising state-funded institutions such as health and education (for instance, Humphreys, 1996, in the UK; and Nursing in Australian Universities Report (National Review of Nurse Education in the Higher Education Sector, 1994), in Australia). In both countries, then, the changes in nurse education were occurring in a political climate reluctant to increase expenditure in the areas of health and education.

This paper will describe the differences in the two levels of nursing in the UK and Australia, and discuss the possible reasons that Enrolled Nurse (EN) training was ended in the UK but maintained in Australia at the time of the transfer of nurse education into Higher Education. It will then analyse the impact of the two different approaches to EN training on skill-mix in the nursing workforce and discuss the implications for the future of the nursing profession in Australia and the UK.

2. The two levels of nursing

In both the UK and Australia, one of the main differences between the enrolled and the registered nurse is the length of training they have engaged in. In the UK for instance, prior to the introduction of 'Project 2000' Registered Nursing courses in 1989 both levels of nurse were trained in hospitals: ENs completed training after two years, and Registered Nurses (RNs) after three. While the theoretical content of the two courses was somewhat different, the nurses’ practical experience on the ward was relatively similar. In Australia, as in the UK, both levels of nurse training were conducted in hospitals, and EN training was shorter than RN training. Yet in Australia the difference in length of training between ENs and RNs was greater than in the UK: in the majority of Australian states EN training was completed in one year, while RN training was completed in three. The main British statutory body for nursing, midwifery and health visiting is the United Kingdom Central Council (UKCC). In Australia the state nursing bodies are represented on and largely co-operate with, the Australian Nursing Council Inc. (ANCi).

3. The ascent of nurse education

Nurse training was originally hospital-based in both the UK and Australia. It has followed a similar progression in both nations in recent years, in that it has converted from apprentice-type training located in hospitals to tertiary training conducted by higher education institutions. In Australia, the transfer of nurse education to the higher education sector was announced by Commonwealth ministers in 1984: nurse training was to move into Colleges of Advanced Education (CAEs), and the move was to be completed by 1993. The State Grant Act of 1985 announced that the qualification on completion of basic nurse undergraduate courses would be an ‘undergraduate diploma’ (Martins, 1990). In Britain the decision to transfer nurse education from hospital-based training to college-based 'Project 2000' diploma courses (mainly conducted in polytechnics) was made in 1989. The same year in Australia a 'unified national system' was introduced in higher education, ending the old binary system of universities and lower-status CAEs and terming all these institutions universities (Gamage, 1993). And in the UK the polytechnics were given university status in 1992. The remaining colleges of nursing were then incorporated into the expanding universities. Hence, the path of nurse education has followed an almost identical course in the UK and Australia over the last fifteen years and in both Britain and Australia nurse education is now largely provided by the university. In Australia however, nursing has subsequently progressed even further in terms of qualification status, with all RN education being upgraded from a diploma to a degree level qualification in 1992.

4. The rationale behind the transfer of nurse education to the higher education sector

This move into higher education was, in both nations, driven by the nursing profession. In the early 1980s, there was concern for the future of nurse education regarding the status and effectiveness of apprenticeship-style nurse training. This style of training was seen as out-dated, ill-equipping nurse trainees for the demands of rapidly changing and expanding health care systems and lowering the morale of nurse trainees due to the conflicting educational and service demands
being placed upon them. This type of training was seen to provide lower professional status in comparison to some other non-medical health care professions (whose training was conducted in the university) and to be contributing to student recruitment and retention problems (RCN, 1985; UKCC, 1986, in Britain; and Parkes, 1986; Martins, 1990, in Australia). In Britain the Royal College of Nursing (RCN) published The Judge Report in 1985 (RCN, 1985), which investigated then hospital-based nurse education, identifying high wastage levels amongst student nurses during training. The Report linked wastage to the exploitation of student nurses as a vital component of the nursing workforce and argued that student nurses should be freed from the obligations of work in order to concentrate on learning. The potential solution was seen by the professional bodies in both the UK and Australia as the termination of hospital-based training, and the transfer of nurse education into higher education.

These recommendations were symptomatic of a growing concern about the ability of nurse education to produce a sufficient number of qualified nurses with the increasingly sophisticated skills necessary to operate in the growing health service (Humphreys, 1996). Certainly there was concern regarding the future path for nurse education in the light of a changing nursing environment throughout the nursing profession. In May 1985 the English National Board also published a document on the future of nurse education (ENB, 1985), with similar conclusions to those of the RCN. In 1986 the UKCC published the results of its own inquiry into nurse education; Project 2000. This report considered the future of nurse education in light of demographic trends and the healthcare demand predicted as a consequence of these. There was consensus in all three reports that educational standards could best be enhanced by breaking the traditional apprenticeship model and placing nurse education under the control of educationalists in a supernumerary model. Practical experience would remain a fundamental feature of any new type of training, but this would be unpaid (student nurses would instead be bursaried). Therefore the relationship between the student and workplace would be greatly altered, with the onus on theoretical education rather than on meeting workforce needs. The reports agreed further that the nurse education award should take the form of a higher education diploma. Thus the changing and challenging demands of the future NHS would be met by a highly qualified and more flexible nurse; her/ his role extending beyond traditional areas to cover health education, sophisticated clinical practice and community care.

In Australia, as in Britain, concerns had been raised regarding the status of nursing and its appeal as a professional career (Goals in Nurse Education (RANF et al., 1976)), as well as the need for a highly-skilled nursing workforce to meet future healthcare demands. Indeed, in Australia this project was initiated significantly earlier than in Britain: many nursing organisations had been pressing for the move of nurse training to higher education for two decades (Parkes, 1986; Parkes, 1992). In 1976, 'Goals in Nursing Education' was produced as a policy statement by the various nursing unions of Australia, arguing for basic nurse education courses to be transferred to Colleges of Advanced Education (CAEs). While there was some initial resistance to the idea of a transfer from government bodies (see Martins, 1990; Parkes, 1992), government-appointed commission reports became gradually supportive of the idea. In Report for the 1985–87 Triennium (Advanced Education Council of the Commonwealth Tertiary Education Commission, 1984), it was argued that the transfer of basic nurse education to CAEs was justified due to the needs of the future in health care provision. The report pointed out that in apprentice-style training, service needs over-shadow those of education, with the consequence that theory is neglected. However, nurses should now be prepared to meet the 'total health care needs' of the future, and multi-disciplinary, tertiary settings would be more conducive to such education. It also observed the concerns of nursing bodies that nurses require college-based training to secure equal professional status with other non-medical professions.

In 1990, following years of campaigning on the part of professionals (Parkes, 1986), the Australian Education Council accepted the recommendation of the final Working Party on Nurse Education Report that the nursing award be changed from diploma to degree status, to commence from 1992.

These changes to nurse education obviously stood to benefit the nursing profession as a whole, as well as potentially creating a more effective system of nurse training. It has long been argued that two of the key aspects of professionalisation of occupations are those actions which improve the group's status and maintain or enhance its control over entry to the profession (e.g. Johnson, 1972). One of the key aims of a professionalisation strategy and an indicator of the extent to which professionalisation has been achieved, is control over the entry gate to the practice of the professional occupation (Johnson, 1972). The higher the entry gate, the more exclusive the knowledge provided in training. By maintaining exclusivity, the profession ensures that its skills and knowledge are scarce, and therefore highly valued (Ainley, 1994). But also, by controlling the type of education provided, the profession consolidates its hegemony over the type of knowledge which constitutes the professional. By moving nurse education away from the control of health care employers and into the higher education sector, the nursing profession was arguably gaining a greater level of control over the
The approach to the split register during these changes differed dramatically in the UK and Australia, however. In Britain a debate over the EN role had been continuing for some time. Many argued that ENs were 'misused and abused' — that employers often expected ENs to perform the jobs of RNs but with lesser remuneration and career prospects (UKCC, 1986). It was claimed that ENs often felt undermined and under-valued and this appeared to be reflected in the falling numbers of students signing up for EN courses in the early 1980s (UKCC, 1986). The Project 2000 report (UKCC, 1986) argued for the termination of training for the role of Enrolled Nurse, envisaging a single grade nurse qualified with a diploma. This would eventually end the split register where two grades of worker are both called 'nurse' and would arguably make the profession more elite as a consequence. The jobs of current ENs were safe-guarded: they could either continue as ENs until retirement, or upgrade to RN level via specially designed 'conversion courses'. The English National Board for Nurses envisaged a relatively low number of ENs taking up these courses but in fact the numbers of ENs who have taken this opportunity to enhance their career have dramatically exceeded that expectation (Humphreys, 1997; Nursing Times, 1997). Project 2000 was implemented from 1989 and the training of ENs began to be formally phased out from that time. This was not the case in Australia, however. Split-level training was retained and in many States both levels of nurse were upgraded. RN training moved from hospitals to universities and the less extensive EN training began in most states to be conducted, partially or totally, in the Technical and Further Education sector (the equivalent of British Colleges of Further Education). While registered nursing became a higher education diploma and then a degree, enrolled nursing was (in most states) upgraded to a further education diploma of between one and two years duration. (The length of EN training varies from state to state. In Western Australia, for example, enrolled nurse education moved from a Hospital Based Diploma to the more theoretical two-year Associate Diploma in Health Science, at the time Registered Nursing education transferred into higher education. Yet most States have retained a one year duration for EN training). Thus the two different levels of nurse were maintained. There was some discussion about ceasing EN training in Australia: the report Nursing Education in Australian Universities (National Review of Nurse Education in the Higher Education Sector, 1994) records a number of submissions which called for a single level of nurse. And indeed, EN training was phased out for two years in the state of Victoria during the early 1990s (Bassett, 1993), but was reinstated after protests from the Australian Nursing Federation and employers. However, such arguments for a single level of nurse was never formally incorporated into the dominant campaign for the transfer of RN training into higher education as it was in the UK. We discuss the possible reasons for this in the next section.
(National Review of Nurse Education in the Higher Education Sector, 1994) observes that there is some evidence of ENs performing tasks which RNs are supposed to carry out in rural districts (where RNs are in short supply), the dramatically shorter training period for ENs means that a clearer delineation between the status of ENs and RNs has been maintained in Australia.

Thus the first possibility is that with the two levels of nursing more clearly differentiated than in the UK, exploitation/abuse of the EN role was not perceived as so pressing a problem. The priority for Australian nursing professional bodies and unions during the late 1970s and '80s was the transfer of Registered Nurse training to higher education (Goals in Nurse Education (RANF et al., 1976)). Enrolled Nursing, further removed from registered nursing and lower in status than in the UK, was not viewed as necessarily part of the same package.

A further possibility is that those in favour of ceasing EN training in Australia were deterred from taking this up as a major campaign due to strong union and employer protection of the EN role. In Britain, the health care workers unions COHSE and NUPE did argue against the termination of EN courses (Humphreys, 1997), but this had little impact. The most powerful British nursing union, the RCN, supported the cessation of EN courses (Humphreys, 1997). Some ENs were RCN members, yet the RCN apparently felt that the Project 2000 strategy best protected the interests of RNs (who formed the vast majority of its members). It did, however, suggest that all ENs automatically become RNs rather than be invited to take conversion courses, although this was not agreed to by the UKCC (Humphreys, 1997). In Australia ENs largely belong to the Australian Nursing Federation, a very powerful union. In comparison with the UK, the Australian EN is substantially lower paid than RNs, and therefore employers support the role. Certainly in the case of the State of Victoria, where EN training was stopped for two years, it appears to have been union action and an outcry from health care employers which led to its reinstatement. So the role of the unions in Australia may have impacted on the feasibility of ending EN training. Moreover, because registered nursing was made a degree in Australia, the professional status of the RN was substantially advanced irrespective of the lower EN nursing qualification.

Finally, the different approaches to EN training between the Australian and British nursing professions may reflect the adoption of alternative strategies for the professionalisation of nursing. Raising the entry-gate to nurse education potentially made the employment of nurses more expensive and left a skills gap at the more menial end of nursing care. The difference in approach to EN training may reflect tactical differences between the Australian and UK professions. As we have discussed, the main priority of the UKCC during the 1980s was to create a higher education-qualified, single-level nurse. This represents a coherent professionalisation strategy: Moloney (1992) argues that the standardisation of education with university preparation as a minimum requirement is one of the key dimensions of professionalisation. Whereas the key intention of the Australian profession had been to make Registered Nursing a degree (Martins, 1990; 'Goals in Nurse Education', 1976). Because the eventual elevation of the Registered Nursing qualification to degree level would involve raising the entry gate, this would leave a larger skills gap than was the case in the UK (where nursing was diploma level). Therefore, in leaving EN training intact, the Australian profession continues to maintain a source of lesser-skilled (and lesser-paid) nursing care for cost-concerned health care employers (we discuss this issue of cost and skill-mix further in the next section).

The reasons for these differences in professional strategy between the Australian and UK nursing professions remain to be resolved. Although both the UK and Australian governments of the time were implementing rationalisation in health care, the Conservative Government in Britain was more radical in its approach (for instance creating an internal market in health care), and more hostile to the professions (Francis and Humphreys, 1999). Therefore a possible explanation might be that the UK profession saw the campaign for a degree-led profession as unrealistic at the time. Further research is needed to establish the various cultural, political and social structural factors which impacted upon the creation of different strategies for professionalisation in the UK and Australian nursing professions.

7. ‘Skill mix’ and nursing care

The phasing out of the EN role left a skills gap in UK nursing care. It was admitted by the UKCC in their Project 2000 proposals that it would be unrealistic to assume that the new, more highly qualified Project 2000 nurses would carry out all the menial and manual tasks involved in ‘basic care’. This would simply prove too costly. The UKCC therefore argued for the creation of a lesser-qualified, non-nurse helper, to aid the RN. Hence the Health Care Assistant (HCA) was introduced. The UKCC’s inclusion of the HCA role in their proposals also represented a sweetener for a hostile government, indisposed to take the advice of the professions. Indeed, it seems probable that the government accepted this professional project because it included the introduction of a new, cheaper
Management Unit, 1996). Figures on HCAs have only been formally kept since 1995. HCAs still comprise a small proportion of the health care workforce, although Snell (1998) reports how in some trusts the figure is as high as 25%. Table 1 shows a whole-time-equivalents increase of 4,854 (37%) in two years, from 1995 when HCAs began being analysed as a single group. Thus HCAs have increased by 2% of the total ‘nursing’ workforce, while numbers of ENs have dropped by 3% of the total workforce, suggesting that non-nurse HCAs have replaced a significant proportion of ENs ‘(real’ nurses). It will be interesting to see whether this suggested trend develops further in the coming years.

These figures suggest that the UK profession may have made a major error in proposing ending EN training and accepting the need for HCAs, as these non-nurses are now apparently replacing ENs in the workforce. Recent reports have supported concerns that HCAs are indeed carrying out complex nursing tasks which ought to be performed by nurses (NHS Executive, 1998; Doult, 1998; Snell, 1998). Debate abounds within the British profession as to whether or not HCAs should be allowed RCN membership or be professionally regulated that they do not perform tasks outside their remit (for example, Nursing Standard, 1997a, 1997b). This issue is problematic for the British RCN, which is a professional body as well as a union. RCN membership for HCAs would allow non-nurses access to protection and representation which some believe should properly only be provided to ‘real nurses’. In this view HCA membership would represent an encroachment by non-nurse HCAs into the nursing profession (Hayward, 1997). Others have argued that regulation of HCAs is imperative, as they are increasingly being pushed by employers to perform tasks for which they are not qualified, consequently endangering patients (Brooks, 1998; Snell, 1998). If these claims are accurate, it does indeed suggest that some health care employers are attempting to substitute cheaper HCAs for nurses, an effect which as has been explained is significant in terms of an erosion of nursing control over care.

The introduction of the HCA role emanated from a formal decision on the part of the UKCC itself in the

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UK. Our argument has suggested that the Australian professional strategy secured the professional control over care, while the UK professional strategy weakened that control (ENs were retained in Australia to fill the lesser-skilled nursing gap). Certainly the Australian profession never acknowledged the need for a new aid to nurses, as had the UKCC in Britain. However, despite this, unskilled healthcare workers are growing in number in Australia. These workers, variously termed 'Patient Care Assistants' (PCAs) or 'Assistants in Nursing' (AINs), are increasingly taken on by health care employers to aid nurses, predominantly in areas such as the Aged Care Sector (Nursing in Australian Universities, 1994). And while the British HCA is usually qualified with an NVQ, the Australian AIN may have no formal training whatsoever. For this reason, the Australian Nursing Federation has begun offering such workers ‘Assistant in Nursing’ courses and other ‘care skills’ certificates (ANF, 1997). Australian nurses are expressing similar fears to their British counterparts concerning the possibility of unskilled, cheap workers replacing qualified nurses (ANF, 1992; ANCI and ARCN, 1997). Nursing in Australian Universities (1994) also reports a proportionate increase in the numbers of ENs in the workforce: while ENs remain a far smaller group than RNs, their numbers have been rising again since RN nursing was made a degree course.

8. The current situation and implications for notions of a degree-led profession in the UK

Therefore, in both Australia and the UK the non-nurse assistant threatens to take over tasks traditionally perceived as 'nursing'. The retention of EN training in Australia did not prevent unskilled AINs encroaching into territory traditionally perceived as that of nursing. It is possible to argue that as the situation stands, the professional strategy of nursing in the UK has had two advantages. Firstly, HCAIs are largely NVQ qualified, and can therefore be expected to have a certain level of competence and some knowledge of their limits (although, because HCAs are controlled by employers rather than the nursing profession, they may be pressured to exceed these limits into areas usually attributed to nursing, as the reports noted above suggest). Secondly, UK nursing has become a single tier profession (albeit not qualified at degree level), and has arguably increased in status as a consequence (Moloney, 1992). However, the degree qualification required as entry to many other non-medical professions in Britain is more prestigious than a diploma qualification. Therefore, it is unsurprising that with the single level, diploma qualification achieved, sections of the British nursing profession are now campaigning for the RN qualification to be raised to degree level. Christine Hancock, General Secretary of the RCN, and Tony Butterworth, chair of the Council of Deans of Faculties of Nursing, argue that it is 'inevitable' that nursing will become a degree, due to the student demand for degrees and the intellectual challenges of the modern health service (The Times Higher Educational Supplement, 1997). The RCN has recently put forward proposals for a new model in nurse education, where all nursing courses would be placed at degree level (Birchenall, 1997; Nursing Standard, 1997c).

In the Australian model the ENs hold the middle ground in nursing, allowing employers a resource of lesser-skilled but qualified nurses to perform duties deemed too difficult for non-professionals, yet too basic to require the expensive skills of degree-qualified RNs. That numbers of ENs have been increasing in the Australian workforce suggests that ENs may be being used to replace expensive graduate RNs (or possibly to fill a general nursing shortage). However, because EN training has been phased out in the UK, the raising of the RN qualification to graduate level would leave a worrying gap in terms of the cost of care skills. Healthcare employers remain under great pressure to minimise costs. If employers are already using HCAs to replace nurses in the workforce, should RN nurses become more expensive a dramatic increase in this practice is likely. HCAs may increasingly be used to replace nursing labour. This scenario would not only be a cause of concern for the patient; but also would mean that non-nurses increasingly encroached on the areas of care provision traditionally constituting nursing duties. As HCAs are not an organised professional group, such encroachment of traditionally nurse care provision would also signify a shift of control to employers concerning the notion of 'nursing' duties. Consequently professional control over the production of discourse on holistic care (May and Fleming, 1997) and the meaning and practice of nursing care may be eroded.

9. Conclusion

It has been shown that while the progression of nurse education over the last decade has followed a similar path in the UK and Australia, the fate of the EN role differed dramatically in the two countries. While EN training was phased out completely in the UK, in Australia EN education was upgraded to diploma level and the role maintained. A number of possible explanations for this difference in approach to EN training have been identified. Evaluating these various explanations, we argue that the greater differentiation between the EN and RN roles in Australia
made the largest contribution to the retention of EN training; the ‘misuse and abuse’ of ENs was perceived as less of a problem than was the case in the UK and the progression of the RN role was seen as the priority for the Australian nursing profession. However, as the strategy of the Australian nursing profession was to professionalise nursing by elevating the RN qualification to degree level, it was politic to leave EN training intact, in order to provide employers with a source of lesser-skilled labour. Certainly the maintenance of EN training in Australia and its termination in the UK, has had implications for work-force skill-mix. Therefore, we have argued that the different approaches to EN training also hold consequences for the future professional control of nursing.

An analysis of the current situation has shown that the retention of EN training in Australia has not kept unqualified workers from performing duties normally associated with nursing. The numerical increase in such workers appears to be as great a cause for professional concern in that country as in the UK. Currently the levels of qualification in Australia simply comprise a more diverse hierarchy than is the case in the UK, from AINs working without formal qualification to RNs at degree level. The UK model falls between these diverse poles, with HCAs awarded a national, albeit basic, qualification and RNs at diploma level. However, our figures show that already non-nurse HCAs are being used as substitutes for ENs in the workplace. If nursing was promoted to degree level in the UK, an even greater skills gap would be left. In Australia this gap can be filled by ENs, but in the UK it would be filled by non-nurse HCAs. Because of this, the nursing profession could lose some of their control over the delineation and practice of nursing care. By maintaining EN training, the Australian nursing profession may have circumvented this problem.

Our argument is not intended to justify the maintenance of low nurse wages or training costs. Rather, by drawing on the logic of the professional project we suggest that if Registered Nursing is to become a degree in Britain, serious thought might be given to the re-introduction of a lower level of nurse. From our analysis of the Australian model, the logical suggestion with regard to the professional project of nursing would be the re-introduction of Enrolled Nurse training. However, in light of the UKCC’s hard-fought campaign to end Enrolled Nurse training, it seems highly unlikely that they would endorse such a move. That accepted, the other potential solution might be for HCAs to take the place of ENs as a cheaper source of less-skilled labour regulated by the nursing profession. HCAs would be registered and their register controlled by the UKCC. (By implication this would also necessitate the provision of access to RCN membership for HCAs). This would be of benefit to the nursing profession as well as to HCAs. It would mean that the nursing profession, rather than employers, decided the working remit of the HCA, including the care tasks (s)he is allowed to perform. In this case, when British nursing becomes a degree-led profession, employers would still be provided with a cheaper source of basic care provision, in the form of the HCA. However, this HCA would be regulated by the nursing profession and thus prevented from endangering the professional hegemony over nursing care by encroaching on nursing tasks outside their remit at the behest of their employers.

This argument is driven by the logic of the professional project in nursing and could be seen as marginalising the needs of HCAs. Certainly the notion of one healthcare occupation controlling another evokes past images of doctors’ surveillance of nurses. However, there might be benefits for HCAs in formal regulation by a group of fellow health workers, that they are not pressured by employers to take on work for which they are not qualified. In developing such a strategy, it would be important to learn from the mistakes of the past concerning ENs and thus to ensure clear training routes to RN level for HCAs, and clear guidance for employers and senior nurses to avoid abuse of the HCA role. Yet by reintroducing the role, the profession might ensure its hegemonic control over the provision of diverse levels of nursing care and thus the constitution of nursing care.

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Education and the professionalization of nursing: 
non-collective action and the erosion of labour-
market control

John Humphreys

It has been argued earlier in this journal that from the formation of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in 1984, until the initiation in 1989 of NHS reform by the third Thatcher administration, nurse education policy development was dominated by a nursing establishment located largely within the UKCC. During this period, in the context of an educational reform, a non-collective professional project emerged which left around 30% of the nursing workforce marooned in an obsolescent occupational group. Drawing on documents from UKCC archives, this paper analyses that professional project in terms of professionalization theory, and argues that by following a non-collective agenda, UKCC eroded nursing’s labour market position in relation to the provision of care in the National Health Service (NHS). It is further argued that this eroded labour market position has subsequently been exacerbated by government-led policy developments concerning vocational education and NHS reform, with a consequent weakening of nursing’s influence on important aspects of caring work in the health service. Explanations for these aspects of the professional project are proposed relating to the fact that although wide-ranging in terms of the nature and practice of nursing, Project 2000 was positioned and conducted as an educational reform. While education provided the ‘political space’ (i.e. free from the immediate priorities and direct involvement of the NHS) for UKCC to assemble and promote its radical professional project, that project as a consequence was uninformed by cost and workforce planning issues. Late stage engagement between professional aspirations and service needs demonstrated the likelihood of an eroded labour market position for nurses, and high levels of risk for the NHS in terms of the supply of nurses, but by that point UKCC was already committed to the key elements of its original proposals.

Introduction

In July 1983 a new statutory structure for nursing was inaugurated, which had at its heart a single UK central council, whose principal function was to establish and improve standards of professional conduct and training. This organization, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) had been conceived by a government appointed committee, whose terms of reference required it to ‘review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role’ (Briggs 1972). Commenting on the wide range of bodies concerned with nursing and midwifery, the committee sought to rationalize and unify these occupations through a statutory administrative structure which avoided fragmentation and overlap. In fact,
although this new statutory structure also included four national boards (for England, Wales, Scotland and Northern Ireland) to arrange and co-ordinate the provision of training, these five new statutory bodies together, did indeed constitute a less-fragmented dispensation, by virtue of the fact that the national boards were required by the Nurses, Midwives and Health Visitors Act of 1979, to discharge their functions subject to, and in accordance with, the rules of the new Central Council.

The creation of the UKCC marked the beginning of a new phase in the professionalization of nursing. Reflecting on its strategic objectives, UKCC identified as a 'chief priority ... the total and radical review of the professional foundation for nursing... with no options foreclosed and with no proposals, however radical, eliminated ...' (UKCC 1986a). In 1984 this review commenced under the title 'Project 2000'.

Prior to Project 2000, two levels of nurse delivered patient care. The first level 'registered' nurse and the second level 'enrolled' nurse. All but 2% of nurse training was delivered within the National Health Service (NHS) at a level equating to non-advanced further education (Goodwin and Bosanquet 1986). As a consequence of Project 2000, 100% of initial training is now categorized as higher education and delivered outside the NHS in Higher Education Institutions. In due course, all nursing provision will be delivered by a single grade of registered nurse. These and other consequences of Project 2000 make the period since 1984, one of the most significant periods of change in the long history of nursing and, arguably in terms of the professional project, one of the most important since the campaign for nurse registration around the turn of the 20th century (Dingwall et al. 1988).

These developments in nurse education and nursing have been described earlier in this journal and analysed in relation to NHS reform under the Thatcher Government (Humphreys 1996d). In this paper Project 2000 is examined further in the context of some of the current generalizations of professionalization theory especially relating to the link between occupational monopoly and the control of work. A process which sheds some light on the possible long term consequences of what will be described below as the non-collective aspects of Project 2000.

Professions, labour and work

The status of professions is based largely on claims by exclusive occupational groups, to practice on a foundation of specialised knowledge normally acquired through advanced education and training. Often distinguishing themselves from other occupations by prestigious attributes such as integrity, strict ethics and high-level skills, professions have been conceived as being at the forefront in the economic, welfare and technological development of society. (Parsons 1963)

While something of this 'naive perspective' (Brante 1990) is retained by the public at large, since the 1960s an alternative view has been elaborated mainly by sociologists, in which professionalism is seen as a strategy through which occupational groups seek to achieve monopoly in sectors of the labour market, and then use that monopoly to achieve high income, power and prestige. This idea, based to a significant extent on Weber's concept of social closure, is seen as a collective strategy for the appropriation of opportunities. It does not suppose that the individuals in the group are necessarily or even usually conscious of their collective interests. Rather it is argued that the tenets of expert knowledge, altruism and concern for public welfare
come to permeate the thinking of the group, forming an ideology which legitimates collective and exclusive material and social rewards. (Johnson 1972).

Commonly professional projects are pursued through both legalistic and credentialistic tactics. The former involving efforts to gain legal monopoly for the occupational group through state licensing, and the latter defining the group and restricting access to it through educational certification. (Collins 1979)

While this type of analysis has led to a more sceptical school of thought in relation to the professions, it is important not to over simplify the position. In the first place, while the credentialistic function of education may play a defining role in the organisation of professional labour, this is not the only significance of education for professionals. Also, although the policies of conservative governments over the period in question imply otherwise, the organisation of labour is not of course necessarily seen as inherently problematic. Both Marx and Engels (1967) for example argued that the task of trades unions was to abolish the undercutting of workers through competition on the supply side of the labour market. As Marx (1982) said in a related context: 'Industry leads two armies into the field against each other, each of which again carries on a battle within its own ranks, among its own troops. The army whose troops beat each other up the least gain the victory over the opposing host.' This quotation (particularly pertinent in the context of the argument below) is illustrative of the view that the organization of labour must be a collective endeavour in order to be effective, as breakdown in solidarity on the supply side effectively erodes or destroys workers' power within the labour market.

However professionalism arguably differs from what might be called proletarian trades unionism (using a contrast supported by Beckham 1990) in the extent to which it involves exclusionary strategies. In terms purely of collective self-interest it makes sense to deny to as many as possible entry to the occupational group, as this pushes up their value in the labour market. But, the feasibility of exclusion correlates positively with the skill levels required in an occupation, as this reduces the options on the demand side (due, for example, to longer training periods), particularly when the profession itself (as is often the case) controls the entry gate. Hence Collins' (1990) identification of the high status occupations as those which are able to organize themselves to limit the supply of skills. Conversely, in occupations requiring relatively lower level or more widely available skills, the limiting factor and therefore the main bargaining resource is less the supply of skills but more simply the supply of labour time. The interests of the occupational group therefore may be most effectively protected by inclusionary strategies, which do not try to close off opportunities, but rather seek to organize across a relatively open workforce.

Clearly this distinction between professional and proletarian occupational group strategies accurately depicts only the furthest ends of a spectrum in which most occupations occupy a more middle ground. It nevertheless usefully serves the present purpose by making a connection between exclusivity and occupational skill level in professional strategies. A point which in the modern world gives a substantial significance to formal higher education in the labour strategies of many professions, more than just defining the group by certification.

The phrase proletarian trades unionism is used here in recognition of the fact that many professional associations in the UK are now technically trades unions, and therefore it is anachronistic to simply contrast professional and trades union strategies without some qualification. However it is recognized that the contrast of professional with proletarian is not unproblematic. In particular there is a substantial question
(which will not be addressed here) relating to where professional groups lie in relation to Marxist class theory. As Burrage (1990) has observed, the professions have variously been placed in the ruling class, in the proletariat, somewhere in between, or as an emergent new class. More significant for the purpose of this paper, however, is the idea that the professionalization of occupational groups involves a striving to cross class boundaries (Parry and Parry 1976) or to put it more loosely a sort of collective upward mobility relative to other groups in society, an idea which gives a further point of contrast between professionalization and other occupational group strategies.

In 1986, the professionally dominated statutory body, the UKCC did hold a strong position in terms of the provision of nursing services, by virtue of the fact that it determined the standards for nursing and nurse education, while also controlling the entry-gate and the official lists of qualified nurses. Furthermore, this was the basis of a relatively strong position more generally in relation to the provision of care within the NHS. In the workplace enrolled nurses and trainee nurses assisted registered nurses. The only threat to the nurses (supply-side) labour market control being the unqualified ‘auxiliaries’ (or ‘assistants’). However the significance of these in terms of the nurses position in relation to professional caring, was severely limited by: a) the fact that auxiliary training was at best very short, locally determined, and did not lead to any nationally recognised qualification; b) the practice of using trainee nurses as part of the workforce, and c) the existence of qualified enrolled nurses (ENs). While (a) left the auxiliaries in a weak position in terms of both status and organization, (b) and (c) kept the more skilled occupational territory that auxiliaries might otherwise have started to fill within the scope of nursing’s control, while also (since trainees and ENs were at the lower end of the pay scales) weakening somewhat the tendency of employers to look to auxiliaries as a significantly more cost-effective option. On these bases, despite the existence of auxiliaries and the significant work they delivered, nurses as a group were sufficiently well positioned in the labour market to embark on a further drive to professionalize.

A further aspect of professionalism is the control that professional groups exert over work itself. Since the client is supposedly ignorant relative to the professional, there is a sense in which entering into a relationship with a professional means entrusting one’s interests to that person. On the basis of this notion it can be argued that to prevent such trust being misplaced or exploited, the professional must have autonomy, that is to say freedom from outside interference in exercising her or his expert knowledge in the interests of the client. Such ‘jurisdiction’ over the occupational area has therefore been considered by Abbott (1988) as a defining feature of professionalism. The same broad argument provides justification both for the rejection of managerial intervention and the retention of control over the body of expert knowledge within the professional group.

However this traditional notion, in which specialist expertise is sometimes used to justify the assumption that only the professional can determine the real needs of the client, has been under attack from several directions. Growing questioning of the supremacy of technical and scientific knowledge, along with the growth of consumerism over the period in question, contributed to the positioning by some of professional autonomy as designed primarily to evade client, managerial and state control, thereby ensuring that the content and practice of professional services remained in line with the professions own predilections, rather than by what governments, employers, or citizens might actually want (Harrison and Pollitt 1994).
In this sense the question of professional autonomy ultimately concerns control over work. By which is meant not only the practice of individual professionals, but also broader issues ranging from the nature of effective practice to the role of particular professions in relation to preferences and goals whose origins lie outside the professional group, such as with an employer, an industry, or the state.

In the next three sections, policy development in nurse education between 1985 and 1989, is interpreted in the light of the above discussion.

**Higher education and the emancipation from direct service control**

Within the scope of this study the first formal manifestation of a developing momentum for change in nurse education was the Judge Report, commissioned by the Royal College of Nursing (RCN) (a professional association and trades union body) and published in 1985 (RCN 1985). In the same year the English National Board (ENB) produced a consultation paper (ENB 1985) and in 1986, the UKCC itself published its 'Project 2000' proposals (UKCC 1986a). These various reports, although containing significant differences of emphasis and detail agreed on some important points of principle. Demographic change and longstanding educational problems were identified which were considered to threaten the supply of qualified nurses. Consequently questions were raised regarding the capability of pre-service education and training programmes to recruit and train an adequate supply of nurses with the necessary skills to operate effectively within increasingly demanding clinical and community environments. In the context of these concerns a 20% wastage rate was generally considered to derive at least in part from what was referred to on occasions as the 'abuse' of student nurses (UKCC 1986a) through their utilization as a necessary part of the clinical workforce. This utilisation is one reason why the pre-Project 2000 approach to nurse training is sometimes referred to as an apprenticeship system.

This apprenticeship model must be seen in the context of the organization of nurse education at that time. In 1986, the NHS was hierarchically organized including larger Regional and smaller District Health Authorities (RHA's and DHA's respectively). In fact DHA's contained not only hospitals and other health care delivery facilities, but also Schools of Nursing. Often Schools of Nursing were quite small organizations attached to a particular hospital. This meant that nurse education and clinical practice were closely linked organizationally. In England schools were financed through Districts (although some funding was derived from the English National Board) who employed all the staff including the Director of Nurse Education (DNE). DNE's were generally responsible to nursing service managers and pre-registration students were actually employees of the DHA.

Broadly in line with conclusions from the earlier reports, Project 2000 came out in favour of breaking the traditional apprenticeship model. No longer NHS employees, it was proposed that student nurses should be supernumerary with their rostered contribution in the workplace confined to the later stages of courses. Supported by maintenance allowances (bursaries), they would be full-time students and indeed working towards a higher education award (the Diploma of Higher Education). The proposed result would be a new single grade of nurse equipped and qualified in sophisticated clinical practice. The adoption of these proposals by the Secretary of State for Health in May 1988, can be seen as a high point of professional influence on
nurse education (Humphreys 1996d). The substance of the proposals represented many of the aspirations of the profession and constituted a consensus across the professional nurse establishment. Dolon (1993) for example, considered it 'hard to overstate the success of nursing compared to other professions at that time. Faced with a radical conservative Government that was bent, it would appear, on breaking the power of the professions, nursing uniquely set its own agenda'.

With Project 2000 accepted, attention turned to implementation, and among the necessary adjustments was a decision by ENB to increase the size of the 'minimum learner population' of viable Schools of Nursing to 300 (ENB 1988). This change had the effect of provoking many School amalgamations and thereby finally ended the organizational intimacy between individual hospitals and their (small) School of Nursing. At the same time the Schools were developing links with Higher Education Institutions in order to gain access to the Diploma of Higher Education awards. In due course and as a consequence of Project 2000 all initial nurse training was relocated out of the National Health Service and into the Higher Education system (Humphreys 1996d).

The interpretation of Project 2000 as the product of a professionally dominated policy process is elucidated when it is considered in terms of professionalization theory as outlined earlier. In simple terms, upgrading the basic qualification of nurses brought them more clearly in line with established professions involved in high-level, theory-based practice. However, in addition to raising the qualifications of nurses, Project 2000 also distanced training from DHA service priorities. In fact, by drawing in higher education institutions and ring-fenced government funding, Project 2000 considerably reduced the influence of DHA's (including hospitals) in which the professional power base had earlier been eroded by the introduction of general managers (DHSS 1983, the Griffiths Report).

It is also worth noting that prior to Project 2000, the development of nursing knowledge and theory (such as it was) was conducted largely within the NHS. The post-Project 2000 linking of nurse education into the Higher Education system, with its tradition of research, had the potential for both accelerating the development of nursing knowledge while also reducing the influence of the NHS over the direction and character of its development.

Therefore the agenda within Project 2000 can plausibly be explained in terms both of increased status and, through the removal of nurse education from the health service, improved control by the occupational group of the body of knowledge.

Non-collective action

Before Project 2000 the concept of 'nurse' spanned a relatively wide range of skill levels across the two grades of nurse: the second level 'enrolled nurse' and the first level 'registered nurse'. The origins of the enrolled nurse can be traced back to problems with recruitment of Registered Nurses in the 1930s. Concerns that the reputation of trained nurses would be eroded by the selection of 'inferior types' to a new lower level nurse grade (UKCC 1985) were eventually outweighed by the need to solve the shortage problem while avoiding inconsistencies which were developing in patterns of employment and remuneration for unqualified staff being taken on to fill the gap. After various reports for and against, action was precipitated by further war-time shortages, and a new level of nurse – the State Enrolled Assistant Nurse
(SEAN) achieved statutory recognition in the Nurses Act of 1943. Further legislation in 1961 removed 'Assistant' from the title and State Enrolled Nurses were finally admitted to the RCN in 1969.

In 1986, among the Project 2000 recommendations were proposals to cease enrolled nurse training and to introduce a new category of worker subsequently named the Health Care Assistant. The eventual achievement of the first of these left existing enrolled nurses as part of a diminishing staff group. The arguments for this were not explicitly about professionalization, and chronic problems were highlighted in relation to the 'use of enrolled nurses at one moment as substitutes for first level nurses, at another as auxiliaries' (UKCC 1986a). Reviewing research evidence, UKCC (1985a) took the view that enrolled nurses were not only 'misused' but also 'abused' (by being treated as inferior) and 'denied' opportunities for advancement.

The issue of the enrolled nurse marked a limit to the professional consensus around Project 2000. Although the statutory bodies were committed to these changes, the responses of nurses’ representative bodies were variable. The Royal College of Nursing supported the single grade (RCN 1986) but other staff-side organizations vigorously argued the continuing value of the second level nurse, and were unconvinced by the arguments for her/his demise. The National Union of Public Employees, for example, favoured the retention of the second level nurse (NUPE 1985), and the Confederation of Health Service Employees while supporting many of the Project 2000 proposals, argued that it left enrolled nurses ‘undervalued, rejected and betrayed by their own profession’ (COHSE n.d. 1985).

Since in 1987, the NHS employed a total of 279,610 qualified nurses of whom 85,020 were second level 'enrolled' nurses, Project 2000 put around 30% of existing nurses into a diminishing staff group. While these enrolled nurses were protected in terms of their ‘licence’ to work and recognition as nurses, they were nevertheless consigned to obsolescent positions and arguably excluded from meaningful nurse status (Humphreys 1996d). Aware of the contentious nature of these proposals the UKCC recommended ‘that enhanced opportunities for enrolled nurses who opt for and are capable of progressing to current first level status should be given high priority’. However it rejected the 'highly controversial' proposal from the RCN that all enrolled nurses should be admitted to registered nurse status on the basis of a period of experience with no further formal training (UKCC 1986a).

In the event, Project 2000 created a large and vigorous market for ‘conversion’ courses through which enrolled nurses could become registered. The widespread provision of such courses generally can be seen as a relatively successful response to the needs of this large and professionally marooned occupational sub-group. It is anticipated that 40,000 enrolled nurses will have successfully converted by the year 2000, with a wastage rate consistently below 5%. A figure that compares very well with the annual drop out rate for initial registered nurse training programmes (Hemsley-Brown and Humphreys 1997).

Despite the numbers of enrolled nurses converting, there is evidence that enrolled nurse conversion was not the consequence of a strong consensus within the professionally dominated statutory bodies with regard to facilitating the interests of enrolled nurses as a group. In fact for many senior nurses, the best policy appeared to be to leave the great majority of enrolled nurses in their protected but increasingly irrelevant position. To quote the ENB from their formal response to the Project 2000 proposals:
The Board do not agree that the options are 'convert or nothing'.... experience shows that only 10—15% of existing ENs are likely to have the capacity successfully to complete the necessary course. (ENB 1986)

Not only have these figures proven to be spectacularly incorrect (Hemsley-Brown and Humphreys 1997) but they also indicate that the professional project of nursing embedded within Project 2000 was not collective. Rather than raising the status of all nurses, Project 2000 as we have seen effectively excluded around one-third of the then nursing workforce from meaningful nurse status, in order to raise the status of nursing. The fact that the second level nurses would be protected until retirement and/or given the opportunity to convert did not make Project 2000 collective in any real sense.

Nursing and the work of caring

The origin of the modern occupation of nursing can be seen in the economic and social changes of the nineteenth century (Corrigan and Corrigan 1979). Nursing along with physiotherapy and social work opened a form of professional life for women, while at the same time being constrained within predominantly patriarchal social structures (Hearn 1982). As a consequence, these occupations arose in areas, which were thought of primarily as the concern of women. This legacy is still apparent in the relationship between nursing and medicine.

Commonly nursing's relation to medicine is positioned in terms of the relationship between 'caring' and 'curing'. While doctors may care about the well-being of the patient, their work is primarily devoted to the diagnosis and treatment of disease and illness (notwithstanding recently increased emphasis on health promotion and disease prevention). The nurse however is still regarded as being primarily devoted to the tending of the patient. Hence the notion that the nurse not only 'cares about' but also 'cares for' the patient. Caring is therefore regarded as a fundamental and defining feature of nursing within the profession (Briggs 1972, McFarlane 1976, Morrison and Burnard 1991, Davies 1995). Furthermore, this 'cares for' concept of caring is regarded by many (McFarlane 1976, Davies 1995) as an essentially holistic idea which, rather than being defined in terms of specific tasks can only be properly captured in the unbounded and broad sense of, as Davies (1995) has put it: 'attending physically, mentally and emotionally to the needs of another and giving a commitment to the nurturance, growth and healing of that other.' Davies goes on to argue that in the public world of paid health care, the nurse is often structurally placed to achieve this, whereas the doctor is rarely so placed (Davies 1995). On this basis, Davies argues that the practice of nursing legitimately 'shades off' at one end of the spectrum into the medical and technical while at the other into domestic work.

This holistic category of argument was used by the UKCC as a basis for proposing the demise of the enrolled nurse. Quoting Pembury (1985) they argued that the: proper initial practitioner role does not exist; it is split between assisting (the role of the enrolled nurse) and managing (the role of the registered nurse in reality) and nursing drops through the vacuum in the middle'. (UKCC 1986a)

However, later in the same chapter:

In an ideal world, most would wish to see registered practitioners give all the care needed. It was always clear, however, that in the real world, the new practitioner could not practice alone. Just as the required advice, so there was a need for assistance.
These passages illustrate tensions within Project 2000, which it will be argued expose a professional project, which is inconsistent with aspects of conventional professionalization theory. Within a few pages, the Project 2000 document first proposed the demise of the enrolled nurse on the ground that she/he was effectively only assisting the registered nurse, while then arguing for the creation of a new helper, because the new registered nurse would need assistance. Moreover while on the one hand acknowledgement is given to a relatively unbounded concept of nursing in which the UKCC 'would wish to see registered practitioners giving all the care needed', on the other care is taken to ensure that the new assistant is by no means given statutory recognition within the newly elite profession:

It remains to suggest a title for the helper. We were anxious to avoid all the existing titles, in order to underline that the new practitioner has a new kind of helper. 'Assistant nurse' not only has 'nurse' in the title which is misleading, but is also associated with the early days of the Roll [ie the register of Enrolled Nurses] and hence linked to a statutory grade. 'Care assistant' is a term in use in social services. We have settled finally for 'Aide'. It is simple, it conveys the notion of being a helper and not a practitioner. There is even a chance that, being short it may actually pass into everyday use and put an end to the indiscriminate use of the term 'nurse'. (UKCC 1986a)

So assistance formerly provided by (enrolled) nurses is replaced by assistance provided by an aide (subsequently called health care assistant) who is barred from nurse status.

This interpretation is corroborated by reference to some of the responses in the Project 2000 consultation phase, which in various ways distanced the new assistant from the new nurse. For example:

The Board felt that the role and function of the 'helper' should take place outside the arena of discussion about the education and training of the professional practitioner. Whilst it is accepted that the profession does not practice in isolation, the report should relate specifically to the professional 'nurse' and the Board would wish to see the title 'nurse' protected in law.

And later:

Of course, the new practitioners will need to have the right to determine the types of support required to be available but it is important that whatever is provided that this does not encroach on the professional status of the nurse. (Welsh National Board 1986)

Such evidence supports the view that the primary motivation behind Project 2000 was not to solve the problem of nursing practice and the 'vacuum' between the first and second level nurses. If this had indeed been the case, then Project 2000 would have more thoroughly adopted its own rhetoric of an unbounded concept of nursing of the sort articulated by Pembury, Davies and others which does indeed imply a single grade of 'practitioner', whose activities shade in to domestic work at one end and doctor at the other. The superficiality of this stance in its Project 2000 form is revealed by the inclusion of the aide, which arguably gave to the Project 2000 document a degree of conceptual incoherence. However, if the primary motivation of Project 2000 is assumed to have been more simply the professionalizing goal of establishing nursing at a higher level, then Project 2000 can be seen as a more coherent (if cryptic) document.

Much of the conflict over Project 2000 from within the profession (outlined in Humphreys 1996d) hinged on these points. While there was general agreement that the status of nurses should be raised, the Project 2000 approach appeared to contradict not only socialist ideas of collective action (Marx 1982) but also feminist arguments that the way to professionalize nursing was not necessarily to move it towards the technical end, but rather to argue that the low esteem given to the broad idea of caring
was part of a gendered conception of profession which should be tackled head on. (See Witz 1992 for an articulation of this position.)

In summary policy development in nurse education between 1985 and 1989 included as part of a professionalization agenda, the reconceptualization of nursing practice that is implicit in: The demise of the lower level Enrolled Nurse; the establishment of a new single level of practitioner corresponding roughly to the old Registered Nurse but with HE training and higher level credentials; and the introduction of the health care assistant, who was (and is) not a nurse, below the new Registered Nurse.

Reflecting on the significance of this in terms of the labour market position of nursing prior to 1986, it seems clear that the pre-1986 position, rather than being enhanced has been eroded. In the first place, the Health Care Assistant is not a nurse and therefore does not fall within the control of the professionally dominated statutory bodies for nursing (Francis and Humphreys 1998). Secondly, the job of Health Care Assistant involves work which to a significant extent was previously the responsibility of trainee and/or enrolled nurses, who did fall within nursing's statutory regulatory structure.

Moreover, linked to this weakening of labour market position is the possibility in the longer term of a challenge to the nurses' control over the work of caring. What has emerged is a recognized occupational group clearly and explicitly distinct from nurses, whose responsibility it is to deliver care. Thus the 'structural' position of nurses within the health service to attend 'physically, mentally and emotionally' to the needs of others (Davies 1995 as quoted above) is no longer the reserved territory of nurses.

The erosion of occupational control

This occupational territory issue became apparent even as Project 2000 was being accepted in principle by the Government in May 1988. From the outset there were caveats of considerable significance – in particular, a ministerial letter to UKCC expressed 'substantial reservations' about the compatibility between the UKCC's proposals and the need to maintain adequate staffing levels (DHSS 1988). In this context the government rejected as 'not realistic' the UKCC's assumptions (used by their consultants Price Waterhouse who had been commissioned to cost the Project 2000 proposals), that the workforce would in future operate with 64–70% qualified staff (i.e. 64–70% registered nurses). (UKCC 1987b). It was in fact considered 'that a professionally qualified workforce of the size, which you envisaged cannot be achieved throughout the UK in the foreseeable future' (DHSS 1988). As a 'principal point' relating to this statement, the Secretary of State placed 'great weight on the proposals being marked up for a new range of support workers' (the aide or care assistant) and asserted the 'need to develop a structure which can be placed within the National Vocational Qualifications training framework'.

In fact as early as two months after the publication of the Project 2000 recommendations document by UKCC in 1986, a white paper had been published entitled Working Together – Education and Training (Department of Employment 1986). The white paper proposed the design and implementation of a new framework for vocational qualifications and led to the setting up of The National Council for Vocational Qualifications (NCVQ): this representing part of a policy development
which ran throughout the 1980s in which 'industry' was increasingly given direct influence on vocational education and training (e.g. Department of Employment 1984, 1986, 1988). As Margaret Thatcher later proclaimed, in her view:

employers... knew more than any expert what skills were actually going to be needed. (Thatcher 1993)

As a result of this policy, the Manpower Services Commission was directed to put in place arrangements for setting standards of occupational competence across all sectors of industry, and it was agreed that these new standards should be defined through Industry Lead Bodies. In this environment it became inevitable (given the determination on the professional side that the helper would not be categorized as a nurse) that influence over the health care assistant would to a significant extent slip further away from the nursing profession and towards employers.

Then a second wave of reform began to impact on nurse education and through it the professional agenda. In 1989, plans were published for the reform of the NHS — in the white paper Working for Patients (DoH 1989). Subsequently the NHS and Community Care Act (DoH 1990) would replace the enormous hierarchical NHS bureaucracy with the so-called internal market. In simple terms, the DHAs were split into distinct purchaser and provider organizations — the former eventually becoming Health Authorities and the latter NHS Trusts. These radical reforms to the structure of the NHS triggered a period of policy development relating to the funding of Nurse Education, which has been analysed in detail elsewhere (Bailey and Humphreys 1994, Humphreys 1996b). The resulting and current arrangements involve the commissioning of nurse education by local 'consortia' of NHS trusts and other stakeholders. These consortia are taking up their roles to become 'operational budget holders' and to 'commission nurse education direct from education providers'. They are also explicitly expected to influence not only numbers but also the 'quality', 'admission policies' and the 'fitness for purpose' of nurse education (EL(95)27).

Thus in 1988 and 1989 two new government policy agendas began their impact on the professional project of nursing. The first agenda — that of Vocational Education and Training consolidating the professional desire to make distinct the care assistant and the nurse by placing the former within the new 'industry-led' vocational framework. The second — that of NHS reform placing employers in purchasing consortia which constitute part of the demand side of a market for nurse education (Humphreys 1996b).

This market for education has survived the election in May 1997 of a Labour government who have in fact expanded it by transferring the funding for nursing degrees from the Higher Education Funding Council for England to the purchasing consortia (Hinde 1997). The agendas of the two sides of this education market are emerging with a degree of clarity. The professional agenda envisages in due course a fully graduate nursing profession; specialist nurse practitioners encroaching on the work of doctors; nurse prescribing; and nursing-led primary care general practices (employing doctors). While the employer agenda, suspicious of professional motives continues to consider the expense of nurses (and nurse education), the extent to which they are far from being flexible generic care workers, and reflects on the gap that enrolled and trainee nurses have formerly filled. (NHSTA 1987, Jowett et al. 1994, Humphreys 1996a, b and c, and Humphreys and Davis 1995b, HMSU 1996, Manning 1997.)

While common ground may emerge around a considerably enhanced role for nurses in the community setting, and perhaps in solving some of the issues around
management and the workloads of junior doctors in acute settings, it is difficult to see how these sorts of enhanced roles can be achieved for nurses while at the same time maintaining the past and current levels of involvement in the direct delivery of care. In fact, in the two years from 1995 to 1997 (later figures are not available at the time of writing) the health care assistant contribution to the delivery of direct patient care has increased at the expense of (enrolled) nurses. While in 1995 nurses (enrolled and registered) made up 95% of the direct patient care workforce — by 1997 that figure had dropped two percentage points — with a corresponding increase in care assistants (Table 1).

There is also an accumulating supply of evidence suggesting that on the back of enhanced in-house training, health care assistants are now indeed encroaching on some of the previously reserved territories of nursing (Warr 1997), and as Alderman (1977) reports, two thirds of Enrolled Nurses now believe that they will be replaced by Health Care Assistants. That these issues reach to the heart of nursing is apparent from the debates going on within the profession, which combine considerable enthusiasm over an enhanced professional role with anxiety over the possibly that in taking this path towards managing and ‘curing’ they will gradually drift away from the broad caring role which has always been both the centre of nurses practice, and the basis of their enormous public popularity. A concern exacerbated by a study (Warr 1997) suggesting that care given by NVQ qualified care assistants compares favourably with that given by nurses (Storey and Jones 1997, Nursing Times 1997).

Explanations: education and the professionalization of nursing

If it is indeed the case — as is argued above — that Project 2000 although motivated primarily as a professional project, had the counter-effect of eroding occupational control over caring, then an explanation as to how the UKCC came to their recommendations is of interest.

In reviewing the history of the enrolled nurse as part of the Project 2000 work, UKCC outlined three models of enrolled nurse that at various times had been proposed: the supervised assistant model in which the enrolled nurse was an assistant to the registered nurse; the equal but different model in which the importance of basic nursing as performed by enrolled nurses was given greater recognition; and the transition grade model in which all would enter nursing through a common portal achieving an enrolled nurse equivalent qualification after 18 months and (for those capable)
progressing to registered nurse after a further 18 months programme. (This latter model had been proposed in the Briggs Report (Briggs 1972) which had also proposed the creation of the UKCC.) The existence of these various models was considered by UKCC as symptomatic of a contentious history of difficulties, and lack of clarity with the role of the enrolled nurse. While it was therefore reasonable for Project 2000 to recommend solutions, UKCC’s approach to the issue of the enrolled nurse is instructive in attempting to explain the eventual outcome.

In seeking to clarify the options, UKCC Project Paper 4 (UKCC 1985b) stated ‘It is no time for tinkering. The EN must either be the subject of thorough going reform or it (sic) must be abolished.’ However, there is nothing in any of the Project 2000 papers and documents which rehearses what thorough going reform might look like, and indeed there is evidence that UKCC had already a clear preferred position. In an earlier Project 2000 Working Paper (UKCC 1985a) UKCC published a ‘close look’ at the case for a single grade of qualified nurse which amounted to just three double spaced typed pages, followed by a recognition that ‘the case has important weaknesses’ that it ‘remains unclear why one level is needed’ and that they were ‘still considering how best to table the positive case for a single grade since there seems at present to be little in print about it.’

Therefore UKCC’s commitment to the abolition of enrolled nursing developed in the absence of any detailed articulation of either the case for such an action or indeed the pros and cons of alternatives (such as tackling unsatisfactory employment practices directly, or the transition model of Briggs (1972)).

These deficits in the articulation and appraisal of options in the Project 2000 development process meant that no real attempt was made during the formulation of the Project 2000 recommendations to determine the nature of the changes which might most effectively achieve the stated goal of improving recruitment to nursing. In this analytical vacuum Project 2000 progressed ungrounded in terms both of the labour market situation and health service resourcing, with which it had at some point to engage. Indeed, the extent to which Project 2000 became an internal process neglecting such questions of feasibility was on occasion almost celebrated:

Feasibility is one thing, however, and justifiability is another! If the profession can put forward an unassailable case that a shift from the present (two level) pattern is professionally desirable, and means better patient care, then such a case deserves to be heard and the challenge will not be whether, but how, to implement it. (UKCC 1985a)

and elsewhere:

the first step for the professions had to be to agree an ideal way forward. (UKCC 1987)

This approach led the UKCC to finally agree their recommendations on 18 April 1986 (UKCC 1986a) before they had been costed — or the workforce implications explored.

Evidence from UKCC archives indicates that analytical engagement between the professional priorities of the UKCC recommendations and the needs of the National Health Service occurred in October 1986 when Price Waterhouse (the management consultancy firm eventually commissioned by UKCC to examine the costs and workforce implications of the recommendations) made a private presentation to the UKCC Council which demonstrated that the Project 2000 recommendations would ‘exacerbate manpower problems, lead to substantial increases in costs, and as a result would be unacceptable’ (to Government). (UKCC 1986b).
There followed on 14 November—seven months after UKCC finalized its recommendations, a confidential paper to Council members examining option packages in which some of the key proposals of Project 2000 were reconsidered, including the recommendation to cease enrolled nurse training (UKCC 1986b). The paper included Price Waterhouse’s figures predicting that the Project 2000 proposals would lead to cumulative shortfalls by 2004 of 200,000 entrants to nursing and 70,000 qualified nurses. Price Waterhouse also stated elsewhere that, of the options available, the continuation of EN training would have the biggest (by far) effect on redressing this shortfall (e.g. reducing the projected 1995 entrant deficit by 28%) (UKCC 1987b).

In considering this position, the confidential paper recognized that second level preparation:

helps maintain a favourable ratio of qualified to unqualified staff. Since the numbers of entrants to first level training will inevitably be constrained by demography it can be argued that it is preferable to make up the shortfall by second level nurses rather than unqualified staff…

Remarkably, the paper also raised the point that:

It could be argued that a two level profession reflects the continuum of nursing care required, and that Project 2000 tends to promote the extremes of this continuum (first level nurses and unqualified aides) leaving a ‘gap’ in the middle.

In the event the only significant change to Project 2000 was to allow a 20% contribution to service by final year students, this being considered inadequate by Price Waterhouse who regarded the position adopted by the Council as a ‘high risk strategy’ which could be seen as ‘placing most of the responsibility of the success or failure of Project 2000 on the service’ (UKCC 1986b). While much of the Price Waterhouse analysis was eventually published (e.g. UKCC 1987b) these opinions were not made public.

In reflecting on this late engagement with the workforce needs of the NHS, it is noteworthy that although having a wide-ranging remit of significance to virtually all aspects of nursing practice (Davies 1995), from the outset Project 2000 was positioned as primarily an educational project. It was conducted initially under the auspices of UKCC’s Educational Policy Advisory Committee consisting virtually entirely of educationalists and without representation from the service side. And although subsequently the Council itself became involved, the recommendations for fundamental change in nursing were published under the title ‘A new preparation for practice’ (UKCC 1986a). It has been argued elsewhere (Humphreys 1994) that although it is often represented as a highly significant educational reform, in purely educational terms Project 2000 had little novelty in it. In positioning nurse education as higher education and trainees as students rather than employees, it simply brought nurse education into line with many other professional groups. Therefore, although representing challenges for health care education providers (Humphreys and Quinn 1994, Humphreys 1995), there are few, if any, new educational principles enshrined within it (Humphreys 1994).

However education provided the professionally dominated statutory bodies with what might be called the political space (i.e. free from the immediate priorities and direct involvement of the NHS) to assemble an ideal-driven wide-ranging professional project under the name of an educational reform. This political space was occupied by the UKCC and its Education Policy Advisory Committee in particular. The successful (if inadvertent) exploitation of this was a key to the ‘success’ of
Project 2000, for it enabled the nursing establishment to effectively promote a professional project whose character reached much further than the training of nurses. However, in this environment Project 2000 lost contact with the needs of the National Health Service and effectively established professionalizing recommendations in an analytical vacuum.

As a consequence, at a critical formative stage in the development of recommendations, UKCC failed to understand that although superficially attractive in professional terms, the demise of the enrolled nurse, combined with the introduction of the 'aide' would as the TUC warned in a paper to UKCC:- 'create a gap in patient care which the aide would inevitably be called on to fill' (TUC n.d.). While this area had been occupied by enrolled and student nurses – it would now become filled by non-nurse aides (care assistants).

Therefore as the future roles of Nurses and Care Assistants emerge over the next few years it is informative to reflect on the fact that, by means of a professional but non-collective agenda, progressed in the context of an inward looking educational reform, nursing eroded its labour market position and thereby weakened its influence on important aspects of the work of caring in the NHS.

Acknowledgements

Documents quoted which relate to Project 2000 including the Ministerial letter; responses to Project 2000 consultation; internal project papers etc, are located in the UKCC library and archive in London as referenced. Many of them are due to be destroyed in May 2000. Thanks are due to the UKCC for access to these documents.

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Chapter 9

Professional education as a structural barrier to lifelong learning in the NHS

Becky Francis and John Humphreys

Introduction

This paper seeks to evaluate and comment upon the extent to which ideals of lifelong learning have been reflected in the training provision for health care workers in the United Kingdom (UK). We begin by providing a brief discussion of the notion of lifelong learning. The extent of demarcation between the education and roles of particular groups of health care workers are then explored, in order to ascertain whether a notion of lifelong learning appears to have been applied to training and career development across different occupational groups in the National Health Service (NHS). It is argued in this paper that professional demarcation perpetuated by various occupational groups is impeding lifelong learning in the health care sector. Finally, we discuss various options for educational routes, which might support lifelong learning in the health care sector and suggest some options for the future.

The notion of lifelong learning

The importance of education for economic development and growth in a global economy is argued in human capital theory, and indeed in many other economic, sociological and educational theories (Ashton and Green, 1996). These various theories maintain that a country can remain competitive in a global market only by providing the workforce with adequate skills, and with the knowledge to enable them to flexibly adapt to new technological innovations and directions (see NCIHE, 1997; Fryer, 1997; DfEE, 1998). This view has not been wholeheartedly embraced by all commentators: some urge a cautious interpretation (see, for example, Ashton and Green, 1996), while others are highly critical of the position. Ainley (1998), for example, argues that there is now a consensus amongst European leaders and policy makers...
Supporting lifelong learning: organizing learning

makers that a certain section of the workforce must remain unemployed in order to restrain national inflation, and to provide a reserve army of labour. Thus some potential workers will inevitably be marginalized despite their skill level, and their extra or re-education provided in any 'learning society' can be summarized as 'Education Without Jobs' (Ainley, 1998). However, the former, positive, view has been embraced in Britain by a Labour government, and indeed broadly represents the consensus view of governments and policy makers throughout the European Union (European Union, 1995; Ball, 1999). Indeed, the expansion of education and training at post-compulsory level, including continuing education or retraining for mature individuals, is seen by government as having the potential not only to secure Britain's continuing competitiveness in a global market (DfEE, 1998; Watson and Taylor, 1998) but also to contribute to solving problems of social exclusion.

The prolific body of research and extensive government policy relating to concerns over social exclusion and global competition have contributed to the development of the concept of the 'learning society', and to related concepts such as 'lifelong learning'. This latter term is a vague one, tending to reflect a particular discourse, which, as Ball (1999) points out, collapses educational policy into economic policy. Hence, although 'lifelong learning' technically concerns all learning from cradle to grave, the term is usually used to refer to the formal education and training of young people and adults. So when individuals participate in continuing education, learning new work-related skills or developing areas of knowledge, they are engaging in lifelong learning (OECD, 1996). Such updating of skills and knowledge is considered vital in the increasingly technological workplace (Watson and Taylor, 1998; DfEE, 1998).

Besides maintaining and upgrading skills for the sake of economic competitiveness, lifelong learning is also portrayed as a source of access to career development and mental stimulation for those who have, for one reason or another, been less successful in initial education (see Fryer, 1997; Watson and Taylor, 1998). This section of society contains a high proportion of individuals from socially disadvantaged groups (see Fryer, 1997), including working-class white men, individuals from certain ethnic minority groups, and women (although currently women are rapidly catching up with men in all areas of education, and overtaking them is some areas; see Francis, 2000). Fryer (1997) observes that social and economic inequality in Britain has widened in recent years, and suggests that lifelong learning has a major role to play in increasing the opportunities of the marginalized sectors of society (who are also often the least educated, leading Fryer to refer to a 'learning divide' in Britain). Hence lifelong learning is perceived as contributing to equal opportunities and to the erosion of social exclusion.
However, within mainstream popular perceptions, education and work tend to remain divided as concepts. Education tends to be understood as something in which children and young people engage until they are 16, after which they enter the world of work, their education complete. Such traditional views are incompatible with the concept of lifelong learning (Fryer, 1997). According to the Green Paper *The Learning Age* (DfEE, 1998), Britain lags behind countries such as Germany and France in terms of the proportion of the workforce qualified to level 3, and indeed there are seven million workers without any qualifications at all in the UK workforce. In order to foster lifelong learning attitudes throughout society, therefore, a major cultural and structural shift is required in our approaches to education and work, where the two are seen as complementary rather than mutually exclusive (Fryer, 1997).

This paper does not seek to evaluate the notion and effects of lifelong learning as a solution to the pressures of a competitive global market place, but rather reflects on these notions of lifelong learning and the learning society in the context of occupational groups within the National Health Service (NHS). It builds upon a previous paper, which analysed the professionalization of nursing via changes in nurse education during the last decade (Humphreys, 1996). Elsewhere we have examined occupational boundaries in the National Health Service and in relation to nursing particularly (e.g. Humphreys, 1997; Francis and Humphreys, 1999a, 1999b). In this earlier work we analysed developments in nurse education and professionalization strategies in nursing in terms of the logic of a professional project. Here we begin instead from the perspective of a British Labour government policy on lifelong learning. Downswell et al. (1997) have already explored the issue of nurses’ learning patterns in relation to a learning society. This paper focuses rather on the implications of occupational boundaries for the notion of lifelong learning.

The NHS is one of the largest employers in Britain, and represents extremely high political stakes (Humphreys, 1997). It therefore presents an interesting and important case for the examination of occupational groups and the extent of their lifelong learning opportunities.

**Doctors, nurses and health care assistants**

Of the various occupational groups represented in the NHS, nurses, doctors and Health Care Assistants (HCAs) have been selected as those on which to focus here. These groups represent diverse sections of the NHS in terms of status and financial reward, but also comprise three important front-line groups in the provision of health services. These three occupations tend to be positioned as fundamentally different kinds of job: HCAs are seen as having an assisting role, nurses a caring role, and doctors a curing role (see Davies, 1995; Humphreys, 1997).
Medicine has traditionally been constructed as a scientific discipline, based on reason, objectivity and scientific experiment. A number of studies have analysed the development of the medical profession, revealing the ways in which this scientific discourse has been propagated and perpetuated by the profession in order to enhance its power (see, for example, Foucault, 1973; Dingwall et al., 1988; Witz, 1992). The construction of the medical profession, and its demarcation from practices deemed to constitute nursing, has been gender-bound. Feminist writers have shown how reason and objectivity are constructed as male traits (Harding, 1991), and from the beginnings of its development, the medical profession deliberately excluded women from 'medical' practice, constructing the nursing and remedies provided by women as 'not medicine'. In recent years the numerical male dominance of the profession has been reduced, as women have entered the profession in ever-increasing numbers (DoH, 1992). However, the dominant construction of medicine as concerned with reason rather than emotion, and curing disease rather than caring for people, remains.

It was in the shadow of this dominant construction of the medical profession that nursing sought to build an identity during the development of the health care professions. Caring is portrayed as the fundamental and defining feature of nursing by the nursing profession (Briggs, 1972; McFarlane, 1976; Morrison and Burnard, 1991; Davies, 1995). However, caring is constructed as a feminine trait in society at large, as are the notions of selfless altruism with which 'caring' is often associated. For example, McFarlane (1976) referred to nursing as the process of 'helping, assisting, serving, caring'. This supports the argument that 'caring' is linked to feminine constructions of selfless altruism, utterly distinct from constructions of the medical role. The helping, nurturing role is often perceived as women's 'natural' role.

In recent years the construction of nurses as assistants to doctors has changed radically in the perceptions of the nursing profession: in the next section the growing confidence and autonomy of the nursing profession are discussed. However, the fundamental notion of nursing as the caring profession persists and is propagated within the nursing profession (see, for example, Morrison and Burnard, 1991; Davies, 1995).

Where the roles of doctors and nurses appear to be constructed in gendered opposition to one another, the care assistant role is constructed as similar to, but clearly distinct from, that of the nurse. They too are involved in assisting and caring. However, they are assistants to nurses. The United Kingdom Central Council's proposals for change in nurse education (the 'Project 2000' proposals, 1986) acknowledged that if nurses were to be qualified with higher education diplomas it was unrealistic to expect that health care employers would be able to afford to employ these nurses to perform 100 per cent of patient care work. They therefore included in their proposals a new type of aide to perform the most basic care tasks. That this new role was separate from nursing was emphasized in the Project 2000 report, which
endeavoured to find a title for the position that sufficiently delineated the divide between assisting and nursing. Having rejected the title 'assistant nurse' because it has 'nurse' in the title, which is misleading, the report settles for 'aide', which it argues conveys 'the notion of being a helper and not a practitioner' (UKCC, 1986: 43). The new 'helper' role was subsequently created, but was in the end titled 'health care assistant'.

Hence the three occupations on which this paper focuses are perceived to perform distinct roles. However, these distinctions are questioned here, and it will be argued that such boundaries are maintained by the professions in a manner that is deeply inconsistent with notions of a learning society.

The roles of nurses and doctors

In recent years the boundaries between the work performed by doctors and nurses has arguably become less distant (Mackay et al., 1995; Read, 1998). Nurse prescribing, and nurses' performance of tasks traditionally undertaken by junior doctors, are two well-publicized examples of an increasing overlap in areas of work. Read (1998) explains that following the government's commitment to improving the working conditions of junior doctors in 1991, it was felt that other professionals might perform some of the tasks then conducted by junior doctors. This led to the creation of new nursing posts including Nurse Practitioners and Clinical Nurse Specialists. Nurse practitioners, particularly, have been found to 'blend' medicine and nursing, bringing a holistic approach to patient care as well as diagnosing diseases (Fenton and Brykczynski, 1993). Christine Hancock (general secretary of the Royal College of Nursing) maintained that nurse practitioners could provide between 60 and 80 per cent of the basic health care currently provided by doctors, and at a lower cost (reported in Nursing Times, 1997). Dowling (1997) has investigated this blurring of boundaries between the nursing and medical professions as nurses move into areas of practice traditionally carried out by doctors in hospitals. She observed that patients and staff often mistook senior nurses for doctors, especially when the nurses were required to wear white coats and were therefore physically indistinguishable.

However, a number of events also reflect the recent shift in the balance of power between doctors and nurses. For example, some of the primary-care pilots where local health services and surgeries are grouped together to pilot new ways of delivering primary care are nurse-led and actually involve nurses employing GPs. According to Porter (1997: 5), this illustrates a 'massive power shift between nurses and doctors'. The location of the basic Registered Nursing diploma course ('Project 2000' courses) in universities has improved the status of nurse training, and many key players in the nursing profession are now arguing for a graduate-led profession (see, for instance, Nursing Standard, 1997). It is claimed that a degree would reflect the high level of
knowledge and practice now expected of nurses working in the NHS, and that the improved status of a degree would attract new applicants to nursing. But significantly, Moore (1998) has also pointed out that an all-graduate profession could finally extinguish the notion of the nurse as a doctors’ handmaid. The nursing profession is increasingly confident concerning the worth and ability of nurses, and is challenging the traditional hierarchy where nursing is subjugated to medicine.

And while the media focus tends to rest on nurses’ progress into territory traditionally occupied by medicine, the movement has not only been one-way. According to May and Fleming (1997) doctors are increasingly appropriating the discourses of holism and care that have traditionally supported nursing. As patients become better informed and more assertive, some members of the medical profession have responded by taking up these holistic approaches that have proved so popular with the public (May and Fleming, 1997).

Hence the dualistic stereotype whereby male doctors cure the sick and women nurses care for them is being deconstructed as nurses take on doctors’ tasks and doctors explore notions of holistic care. It is argued here that the benefits of this cross-fertilization also highlight the redundancy of the caring/curing dichotomy: nurses can use their skills and knowledge to help cure patients, and doctors care for (as well as about) their patients.

**The role of RNs, ENs and HCAs**

Similar blurrings of role also apply amongst lower grade nurses. Indeed, a lack of clarity or separation of roles in nursing has dogged the profession for more than a century (see Dingwall et al., 1988). In the UK the nursing register is split between Registered Nurses (qualified on three-year courses) and Enrolled Nurses (qualified on two-year courses). Enrolled nurse (EN) training has now been phased out, following proposals from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and other nursing bodies (see UKCC, 1986; Humphreys, 1996; Francis and Humphreys, 1999b, for elaboration). One of the UKCC’s main arguments for ending enrolled nurse training was the ‘misuse and abuse’ of enrolled nurses by employers who often expected enrolled nurses to perform the tasks of registered nurses, but with less status or remuneration (UKCC, 1986). Despite the cessation of enrolled nurse training, confusion over ‘Rule 18’ remains. (Rule 18 is the item in the UKCC’s *Scope of Professional Practice*, 1992, which sets out the boundaries of enrolled nursing, but it is notoriously vague and tends to be interpreted differently by different employers, see Francis and Humphreys, 1999b.)

The potential of enrolled nurses as a group has been demonstrated by the large number who have succeeded in elevating themselves to the level of registered nurse via ‘conversion courses’. These courses were mainly initiated
following the decision to end enrolled nurse training, in order to alleviate fears that existing enrolled nurses were being abandoned and marginalized as a group (Hemsley-Brown and Humphreys, 1998). At the time the English National Board (ENB) had expected that, 'only 10–15% of existing ENs are likely to have the capacity successfully to complete the necessary [conversion] course' (ENB, 1986), but in fact the figure is closer to 50 per cent (Humphreys, 1997).

Yet the 'misuse and abuse' scenario now appears to be transferring to the case of HCAs, who represent a rapidly growing segment of the health care workforce. Alderman (1997) reports that two-thirds of enrolled nurses believe that they will be replaced by HCAs, supporting Humphreys' (1997) view that HCAs will become the new, but non-nurse, enrolled nurse equivalent. Certainly they are performing tasks that have previously been the remit of nurses (Snell, 1998; Francis and Humphreys, 1999b). While HCAs theoretically only 'assist' in care-giving, as with the case of enrolled nurses the confines of the role are not in practice clearly delineated (Francis and Humphreys, 1999b).

**Opposition on the part of individual professions**

Thus the boundaries between these health care options are somewhat blurred both in terms of the various tasks performed by each, and perceptions of their roles. The encroachment tends to be 'upward' in terms of the career hierarchy, as it is encouraged by two different forces: on the one hand, employers attempting to reduce costs by employing lesser-qualified workers to perform jobs previously performed by more highly qualified, and thus highly paid, workers; and on the other hand by the occupational movements attempting to improve the status of the occupational group. However, this encroachment by certain occupational groups into the traditional domains of others has been criticized and opposed by the professions into whose territory they are moving. As demonstrated by a report on discrimination against nurses by GPs (Kenny, 1997), some doctors are threatened by assertive nurses and rather prefer to see nurses as their assistants. The view of pseudonymed medical consultant Hippocrates Spratt (*Sunday Telegraph*, 1997) that nurses have grown 'stroppy' as a result of their new Project 2000 qualifications illustrates how confident and highly qualified nurses can be seen as a threat by doctors. Similarly, Sims (1997) reports that some doctors were initially concerned by the notion of nurse prescribing, as it represented an erosion of the doctor's role.

However, often there is also disquiet regarding the ability of individuals to carry out the new tasks. Nowhere is this anxiety greater than in relation to the role and functions of HCAs. Many in the nursing profession are concerned that because HCAs are relatively cheap, employers may be tempted to substitute HCAs for qualified nurses in order to cut costs, and
indeed HCAs have been shown to be replacing enrolled nurses in the health care workforce (Francis and Humphreys, 1998a, 1999b). Recent reports have supported concerns that HCAs are indeed carrying out complex nursing tasks that 'ought' to be performed by nurses (e.g. Doult, 1998). Debate abounds within the British profession as to whether or not HCAs should be regulated by the nursing profession in order to prevent them from performing tasks outside their remit (see Francis and Humphreys, 1998a, 1999b). Indeed, from the logic of a professional project we have argued that there would be advantages in this for the nurses in that they could work to prevent the encroachment on their work and maintain the conceptual distinction between 'assisting' and 'caring'. However, as we have sought to show above, these jobs (doctor, nurse, HCA) in fact constitute a spectrum of roles, tasks and skills in which there are overlaps as well as differences, and a lack of fundamental boundaries. It is argued here that rather than describing distinct roles and practices, such professional titles to a considerable extent reflect historical gender and class boundaries, and the endeavours and constructions of professional projects.

From occupational boundaries to social exclusion

Professions seek to increase their autonomy and status by self-regulation, and in particular, regulation of the professional entry gate (e.g. Moloney, 1992). Professional control over the level and content of education and qualification for membership of a profession maintains exclusivity (Ainley, 1994), and ensures that education is separate from employment issues (such as the cost concerns of employers, see Humphreys, 1997; Francis and Humphreys, 1998b), allowing the profession to decide the direction and nature of the profession. The programme by which these factors are increased has been termed 'professionalization' (Moloney, 1992).

The higher the entry gate to a profession, the more exclusive the knowledge provided in training. By maintaining exclusivity, the profession ensures that its skills and knowledge are scarce, and therefore highly valued (see Ainley, 1994). The medical profession has been extremely successful in defining and controlling the constitution of, and entry gate to, medical practice; and is one of the most powerful professions. It is no coincidence that nursing, an overwhelmingly female profession, is far less powerful: as was observed above, the nurse has traditionally been conceptualized and presented as the (male) doctor's helper. However, nursing has engaged in its own professionalization programmes (Witz, 1992). The move to Project 2000 diplomas, and the growing campaign for a graduate-led profession provide two examples where nurses have sought to raise the entry gate to their profession in order to enhance the status of nursing, and arguably to gain greater control over its regulation and autonomy (see Humphreys, 1997; Francis and Humphreys, 1999b). The Project 2000 proposals (UKCC, 1986)
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were keen to demarcate the HCA role from nursing. To HCAs who wished to train to become nurses, the report warned,

The would-be entrant should be advised, however, that all the normal entry requirements will apply and that while work as a helper will serve to give an appropriate character reference, it cannot operate either as an entry gate or as credit towards professional preparation.

(UKCC, 1986: 43)

Thus the nursing profession, like many other professions, has attempted to raise the entry gate to the profession and to draw clear divides between the nursing role and other less prestigious health care occupations.

If employers or government are empowered to influence professional education, they are likely to attempt to instigate changes in education, possibly with a view to producing more flexible, and possibly cheaper, future workers (see the case of health care consortia and nurse education, discussed in Humphreys, 1996 and Francis and Humphreys, 1998b, for a discussion of these processes). We have argued elsewhere (Francis and Humphreys, 1998b) that such employer control holds potentially negative connotations for the quality and direction of education provided. Conversely, however, our analysis here suggests that occupational control of educational institutions creates a barrier to lifelong learning. This is because occupational exclusivity mediated through education is fundamentally inconsistent with the amelioration of social exclusion. Yet, as the status of professions depends on the maintenance of demarcation and exclusion, it is predictable that the various health care professions would seek to maintain and perpetuate occupational boundaries.

So despite the reduction in distinction between the roles of health care professions and the increasing fuzziness of boundaries, practices of elitism and exclusion remain within the distinct occupational groups, and this is reflected in the limited or non-existent access to interprofessional training, or accreditation of prior learning schemes. In Britain it remains the case that, supposing that a nurse sought to become a doctor, or a doctor a nurse, each would have to start at the beginning of their respective new training, despite their existing knowledge (e.g. of human physiology, health care, clinical practice, etc.). This is not the case within professions. For example, nurses wishing to learn midwifery do not need to start again at the beginning, but can undertake an eighteen-month course rather than the normal three-year course, as their experience and qualification as nurses is deemed to contribute substantially to their knowledge and training for qualification as midwives. This inflexibility between occupational groups has been suggested to impact on levels of recruitment to nursing, at a time when the profession is suffering recruitment problems (Francis and Humphreys, 1998b): Foskett and Hemsley-Brown (1998) report that school pupils frequently mentioned
inflexibility in education and occupational role between health care professions as a disincentive to enter nursing.

Such rigid delineation between occupational groupings is clearly in opposition to the concept of lifelong learning. Indeed, it is arguable that such occupational exclusivity maintains a form of social exclusion. Although notions of lifelong learning and structures for the accreditation of prior learning have been widespread, there is little evidence of coherent career development paths in the domain of health care and, particularly, in nursing. Indeed, there is much evidence that shows that while nurses spend a great deal of time and energy working for extra qualifications and gaining new skills, these endeavours go unappreciated by employers (Dowswell et al., 1997). This tends to be due to a lack of career guidance (so that the new skills are not geared towards a particular career direction), and an absence of a clearly defined career structure in nursing. Butterworth (1998) argues that the clinical or academic career paths for nurses and midwives are ill-defined, in stark contrast with the medical profession. We would go further and suggest that any such defined career structure should explicitly include progression from one occupational group to another, and that curriculum development should be such that mechanisms like the accreditation of prior learning can be introduced to facilitate movement across occupational boundaries.

The achievements of enrolled nurses in progression via conversion courses provides an illustration of the potential here. It is recognized that the motives for enrolled nurses to take up conversion courses were mixed: some feared that their jobs might be phased out, and others were pressured to participate in the courses by their employers (Hemsley-Brown and Humphreys, 1998). Yet the majority declared excitement at the provision of the opportunity to upgrade, an enthusiasm for learning, as well as a commitment to successfully upgrading their position (Hemsley-Brown and Humphreys, 1998). That a large proportion of enrolled nurses were eager to take the opportunity to improve their qualifications and occupational position suggests the potential of individuals within the health care workforce to progress and achieve higher status and greater responsibility if provided with the opportunity. Moreover, as was observed above, the English National Board for nursing expected only a small fraction of enrolled nurses to achieve the conversion to registered nurse level. The English National Board had declared that, 'experience shows that only 10-15% of existing ENs are likely have the capacity successfully to complete the necessary course' (ENB, 1986). That their estimate was 'spectacularly incorrect' (Humphreys, 1997: 11), with numbers of enrolled nurses achieving conversion exceeding all expectation, arguably illustrates the embedded, erroneous prejudices of the professional bodies against lower-status groups. It appears that the English National Board's prediction was not based on an accurate assessment of the capabilities of those in lower occupational groups to progress, but rather
reflected a preoccupation with professionalization, arguably at the expense of less powerful groups (Humphreys, 1997).

This analysis, then, suggests that the elitist and anachronistic approaches of health care occupations are currently impeding occupational and educational flexibility in the NHS, and are as such fundamentally inconsistent with any sophisticated and egalitarian concept of lifelong learning. This bears considerable significance for government agendas concerning lifelong learning, which will remain rhetoric rather than practice unless underpinned by more radical change to the occupational structures, occupational power and society generally.

Health care education: the future?

The above conclusion suggests the need for radical solutions in terms of health care education. In the current British health care environment where demand for care continues to exceed funding, and new innovations, technology, and a discourse of holistic care increasingly blur traditional occupational boundaries, it is unsurprising that a number of studies have discussed new interprofessional approaches to health care education. For example, Koppel (1998) and Freeth et al. (1998) have examined and evaluated 'interprofessional education'. This term refers to learning activities where members of different professions learn with and from each other (Koppel, 1998). Koppel identifies a number of benefits resulting from this interprofessional approach, such as improved quality of care, a flexible workforce and greater cost-effectiveness in educational institutions. Freeth et al. (1998) maintain that such interprofessional learning might reduce the occurrence of communications breakdowns and ignorance of other team members' roles and expertise, in multidisciplinary health care teams, as well as avoid 'unhelpful protectionism' (see also Mackay et al., 1995). Like Koppel (1998), Freeth et al. suggest that interprofessional education can increase morale, efficiency, communication and the quality of care provision.

However, the interprofessional learning described in these studies is based on a notion of collaboration between bounded professions, rather than a deconstruction of professional boundaries in the workplace and educational facilitation for crossing them (lifelong learning). Moreover, both studies focus on small work-based schemes rather than on general pre-professional education. Koppel (1998) does allude to a different type of education, often confused with interprofessional learning: multiprofessional education. This he describes as a 'much wider enterprise', where learners share the same educational facilities. He argues that the vogue for such education reflects the scarcity of educational/health care resources, and a consequential attempt to reduce the expense of professional education. Koppel distinguishes this from interprofessional education where learners learn from each other with the intention of working together more efficiently.
Koppel’s description of multiprofessional education echoes a widespread concern in health care circles. The fear that cost-cutting is driving the blurring of roles in health care has been discussed above, and has been demonstrated to be justified in some cases (Francis and Humphreys, 1999b). Notions such as that of the ‘generic healthcare worker’ (Health Services Management Unit, 1996), where a low-cost, flexible worker would be used to fill multiple roles, have generated consternation in nursing circles (see Francis and Humphreys, 1998b). However, it is argued here that multiprofessional education should not necessarily be perceived as a way to cut costs, or to produce a generic care worker. Rather, it is maintained that such education is required to ensure the opportunity for lifelong learning and development throughout the health care occupations.

Two interrelated educational strategies are suggested. The first concerns a more flexible basic education for health care workers. This would help to provide a suitable beginning point in order to facilitate diverse paths of future education and career development (enshrined in the discourse of lifelong learning) among health care workers. The second strategy concerns a clear structure of post-professional development, allowing individuals to maximize and develop their potential throughout their working lives, and hence helping to realize the principles of equality of opportunity and personal development maintained in the discourse of lifelong learning.

Responding to the shortage of recruits to nursing, the recently published report Perceptions of Nursing as a Career (Foskett and Hemsley-Brown, 1998: 3) argued that young people’s perception of nursing as a future career would be ‘enhanced by the establishment of a common basis for medical training in HE that was shared between medicine, nursing and Professions Allied to Medicine [PAMs]’. Foskett and Hemsley-Brown further maintain that transfers between the various health care careers should be facilitated. Our analysis supports that argument, and suggests the introduction of common basic higher education components for the health professions where roles, and therefore learning, overlap between them. Clear structures of accreditation should be introduced in order to allow capable HCAs and other lesser-status health care workers access to this Higher Education programme. For example, under the current system an NVQ in health care at Level 3 can be used to gain entrance to a nursing diploma course. However, able and experienced HCAs will already have learnt and practised many of the basic tasks taught in a nursing diploma course, and reteaching them such skills constitutes an inefficient use of time, money and energy. If a system of Accreditation of Prior Learning (APL) were introduced, the HCA would not be forced to ‘relearn’ those tasks, but could ‘fast track’ to other subjects. HCAs constitute a particularly appropriate group as potential beneficiaries from such strategies, representing as they do a relatively powerless and under-educated group in the health care workforce. As such, improving their personal and financial remuneration via structured training routes would
particularly support the ethos of enfranchisement expressed in much discourse on lifelong learning (e.g. Fryer, 1997). However, this APL system would be equally applicable to a doctor or nurse wishing to change specialism.

This clearly defined structure of educational accreditation for all health care workers, then, would make the transfer from one level to another more accessible, and would widen participation and opportunity as a consequence. The success of the large proportion of ENs in completing conversion courses to RN level demonstrates that health care workers do indeed have the potential to develop new areas of knowledge beyond those anticipated by the dominant professional establishments or implied by their youthful performances in school. Workers already employed at lower levels in the health care workforce might provide an important source of recruitment in areas such as nursing, which are facing shortages (Buchan et al., 1998; Francis and Humphreys, 1998b), or indeed medicine. It is vital, however, that quality and standards are maintained. The agenda would therefore be to ensure that the creation of any new educational approach in health care is driven by the values of opportunity, high standards and broad participation espoused in the rhetoric of lifelong learning, rather than by those simply of economic rationalization or occupational self-interest.

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